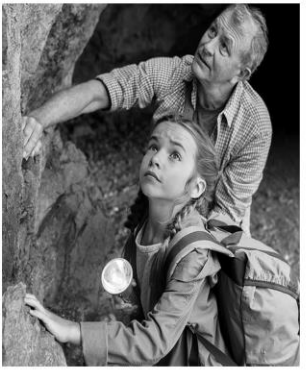
Administered by:

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company






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

Lincolnway Area Affiliation (Illinois School Insurance Network)

294492 - BA 0059 $1,000 BCO PPO Plan

A message from

Lincolnway Area Affiliation (Illinois School Insurance Network)

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Sincerely,
Lincolnway Area Affiliation (Illinois School Insurance Network)

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Prescription Drug Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your Identification Card.

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BENEFIT HIGHLIGHTS

Your benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

UTILIZATION MANAGEMENT AND REVIEW	A special program designed to assist you in determining the course of treatment that will maximize your benefits described in this benefit booklet
Lifetime Maximum for all Benefits	Unlimited
Individual Deductible	
— Blue Choice Options Provider	$1,000 per benefit period
— Participating Provider	$2,500 per benefit period
— Out-of-Network and Non-Administrator Provider	$5,000 per benefit period
Family Deductible	
— Blue Choice Options Provider	$3,000 per benefit period
— Participating Provider	$7,500 per benefit period
— Out-of-Network and Non-Administrator Provider	$15,000 per benefit period
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	
— Blue Choice Options Provider	$2,500 per benefit period
— Participating Provider	$5,500 per benefit period
— Out-of-Network	$11,000 per benefit period
— Non-Administrator Provider	No limit
Family Out-of-Pocket Expense Limit	
— Blue Choice Options Provider	$5,500 per benefit period
— Participating Provider	$10,200 per benefit period
— Out-of-Network	$26,400 per benefit period
— Non-Administrator Provider	No limit
Private Duty Nursing Service	No benefit maximum
Chiropractic and Osteopathic Manipulation Benefit Maximum	75 visits per benefit period

HOSPITAL BENEFITS	
Payment level for Covered Services received from a **Blue Choice Options Provider:**	
— Inpatient Covered Services	90% of the Eligible Charge
— Outpatient Covered Services	90% of the Eligible Charge
— Urgent Care	$50 Copayment, then 100% of the Eligible Charge, no deductible
Payment level for Covered Services received from a **Participating Provider:**	
— Inpatient Covered Services	70% of the Eligible Charge
— Outpatient Covered Services	70% of the Eligible Charge
— Urgent Care	$50 Copayment, then 100% of the Eligible Charge, no deductible
Payment level for Covered Services received from an **Out-of-Network Provider:**	
— Inpatient Covered Services	50% of the Eligible Charge
— Outpatient Covered Services	50% of the Eligible Charge
— Urgent Care	50% of the Eligible Charge
Payment level for Covered Services from a **Non-Administrator**	50% of the Eligible Charge
Hospital Emergency Care	
— Payment level for Emergency Accident Care received either Out-of-Network or from a Non-Administrator Provider	90% of the Eligible Charge
— Payment level for Emergency Medical Care received either Out-of-Network or from a Non-Administrator Provider	90% of the Eligible Charge

PHYSICIAN BENEFITS

Payment level for Surgical/ Medical Covered Services	
— **Blue Choice Options Provider**	90% of the Maximum Allowance
— **Participating Provider**	70% of the Maximum Allowance
— **Out-of-Network Provider**	50% of the Maximum Allowance
Payment level for Covered Services received in a Professional Provider's Office	
— **Blue Choice Options Provider** (other than a specialist)	$25 per visit, then 100% of the Maximum Allowance, no deductible
— **Blue Choice Options Provider** (Specialist)	$50 per visit, then 100% of the Maximum Allowance, no deductible
— **Participating Provider** (other than a specialist)	$50 per visit, then 100% of the Maximum Allowance, no deductible
— **Participating Provider** Specialist	$100 per visit, then 100% of the Maximum Allowance, no deductible
Payment level for Emergency Accident Care when rendered by a Physician	90% of the Maximum Allowance
Payment level for Emergency Medical Care when rendered by a Physician	90% of the Maximum Allowance

OTHER COVERED SERVICES

Payment level	90% of the Eligible Charge or Maximum Allowance
Hearing Aids	Benefits for one Hearing Aid will be covered for each ear every 24 months

TELEHEALTH AND TELEMEDICINE

Payment level for Telehealth Services	
— Participating Provider (other than a specialist)	$25 per visit, then 100% of the Maximum Allowance, no Deductible

— Participating Provider (Specialist)	$50 per visit, then 100% of the Maximum Allowance, no Deductible
— Non-Participating Provider	50% of the Maximum Allowance

Payment level for Telehealth Services for the treatment of Mental Illness

— Participating Provider (other than a specialist)	$25 per visit, then 100% of the Allowance Allowance, no Deductible
— Non-Participating Provider	50% of the Maximum Allowance

PRESCRIPTION DRUG PROGRAM BENEFITS

Copayment

— Tier 1 Generic Drugs and generic diabetic supplies	$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 non-preferred brand name diabetic supplies	$60 per prescription

Home Delivery Prescription Drug Program

Copayment

— Tier 1 Generic Drugs and generic diabetic supplies	$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 non-preferred brand name diabetic supplies	$120 per prescription

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

The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $35, when obtained from a Preferred Participating or Participating Pharmacy.

Certain covered drugs may be available at no cost through a Participating Pharmacy for the following categories of medications severe allergic reactions, hypoglycemia, opioid overdose, and nitrates. For further information, please call the toll-free telephone number on the back of your Identification Card.

*BENEFITS FOR AUTISM SPECTRUM DISORDER(S) WILL NOT APPLY TOWARDS AND ARE NOT SUBJECT TO ANY PHYSICAL, SPEECH OR OCCUPATIONAL THERAPY VISITS MAXIMUM.

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

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.

ACUTE TREATMENT SERVICES.....means a 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist operating within the scope of their certification.

AMBULANCE TRANSPORTATION.....means local transportation in specially equipped certified ground and air ambulance options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this health care plan.

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE.....means i) for ambulance providers that bill for Ambulance Transportation services through a Participating Hospital the Ambulance Transportation Eligible Charge is the applicable ADP, and ii) for all other ambulance providers, the Ambulance Transportation Eligible Charge is such provider's Billed Charge.

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.

An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them, respectively.

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

(ii) A clinical trial conducted under an FDA experimental/investigational new drug application, or

(iii) A drug that is exempt from the requirement of an FDA experimental/investigational new drug application.

AUDIOLOGIST.....means a duly licensed Audiologist operating within the scope of their license.

A "Participating Audiologist" means an Audiologist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time Covered Services are rendered.

A "Non-Participating Audiologist" means an Audiologist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Covered Services to you at the time Covered Services are rendered.

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 autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

AVERAGE DISCOUNT PERCENTAGE ("ADP").....means a percentage discount determined by the Claim Administrator that will be applied to a Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Treatment benefits, including Prior Authorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Use Disorder.

BILLED CHARGES.....means the total gross amounts billed by Providers to the Claim Administrator on a Claim, which constitutes the usual retail price that the Provider utilizes to bill patients or any other party that may be responsible for payment of the services rendered without regard to any payor, discount or reimbursement arrangement that may be applicable to any particular patient. This list of retail prices is also sometimes described in the health care industry as a "chargemaster."

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.

BLUE CHOICE OPTIONS.....means a network of selected Providers established by the Claim Administrator.

CARE COORDINATION.....means organized, information-driven patient care activities intended to facilitate the appropriate responses to participant's health care needs cross the continuum of care.

CARE COORDINATION FEE.....means a fixed amount paid by a Blue Cross and/or Blue Shield plan to Providers.

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 or CRNA.....means a nurse anesthetist 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 and is operating within the scope of their license.

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 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 (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor operating within the scope of their license.

A "Participating Clinical Professional Counselor" means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Professional Counselor" means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker operating within the scope of their license.

A "Participating Clinical Social Worker" means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Social Worker" means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL STABILIZATION SERVICES.....means a 24-hour treatment, usually following acute treatment services for Substance Use Disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

CLINICIAN.....means a person operating within the scope of their license, registration or certification in the clinical practice or medicine, psychiatry, psychology, or behavior analysis.

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 Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

CONGENITAL OR GENETIC DISORDER.....means a disorder that includes, but is not limited to, hereditary disorders. Congenital or Genetic Disorders may also include, but is not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

CONTRACTED PROVIDER.....means a Participating Provider and a Participating Professional Provider, collectively.

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. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you 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 advanced practice nurse with a collaborating agreement with a Physician that delegates that authority. This program includes physical, occupational and speech therapists, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service or Custodial Care Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An "Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A "Non-Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

(i) A group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

(iv) Medicaid (Title XIX of the Social Security Act).

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.

(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

(x) A health plan under Section 5(e) of the Peace Corps Act.

(xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

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 your 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).

DEDUCTIBLE.....means the amount of expense that you must incur in Covered Services before benefits are provided.

DENTIST.....means a duly licensed dentist operating within the scope of their license.

DIAGNOSTIC MAMMOGRAM.....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 rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease, or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans 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, when operating within the scope of such license.

An "Administrator Dialysis Facility" means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Dialysis Facility" means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

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.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider, when operating within the scope of such license.

EARLY ACQUIRED DISORDER.....means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that 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.

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a covered person in the benefit program or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services for medical benefits are rendered by a Participating Provider, such Participating Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services for medical benefits are rendered ("Non-Participating Provider"), the following amount (unless otherwise required by applicable law or arrangement with the Non-Participating Provider):

(i) the lesser of (a) the Provider's Billed Charges and (b) an amount determined by the Claim Administrator to be approximately 400% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the

information submitted on the Claim, the lesser of (a) the Provider's Billed Charges and (b) an amount determined by the Claim Administrator to be 400% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the Eligible Charge cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 400% of the Provider's Billed Charges, provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to the covered person.

The Claim Administrator will utilize the same Claim processing rules, and/or edits, that it utilizes in processing Blue Choice Options and Participating Provider Claims for processing Claims submitted by Out-of-Network Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services. The initial Outpatient treatment does not include surgical procedures, including but not limited to, stitching, gluing, and casting.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying 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 that the absence of immediate medical attention could result in:

(i) placing the health of the individual (in the case of a pregnant woman, the health of the fetus) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

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 MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorders condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

ENROLLMENT DATE.....means the first day of coverage under your Employer's health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL.....means the use of any treatment, procedure, facility, equipment, drug, device, or supply (including emerging technologies, services, procedures, and service paradigms) not accepted as Standard Medical Treatment for the condition being treated or, if any of such items required federal or other governmental agency approval, such approval was 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, surgical, mental health treatment, Substance Use Disorder Treatment, 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:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-fixed programs in making its determination.

Although a Physician or Professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort. The Claim Administrator still may determine such services or supplies to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational.

Approval by a government or regulatory agency will be taken into consideration in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative. Prescription drugs that are approved by the FDA through the accelerated approval program may be considered Experimental/Investigational.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

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 coverage 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 within the scope of such license.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider, when operating within the scope of such license.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service, when operating within the scope of such license.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological, and spiritual care for dying 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, Skilled Nursing Facility, or special hospice care unit.

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.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

IATROGENIC INFERTILITY.....means an impairment of fertility caused directly or indirectly by surgery, radiation, chemotherapy, or other medical treatment, affecting reproductive organs or processes.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INFERTILITY.....means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy.

INFUSION THERAPY.....means the administration of medication 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.

INTENSIVE OUTPATIENT PROGRAM.....means a freestanding or 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 Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use

Disorder. Requirements: the Claims Administrator 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 the Claims Administrator, as set forth in the current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute Inpatient, residential care.

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 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 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 measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist operating within the scope of their license.

A "Participating Marriage and Family Therapist" means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means (a) the amount which Blue Choice Options or Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Blue Choice Options or Participating Professional Providers will be based on a Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. Benefit payments for Covered Services rendered by Blue Choice Options Professional Providers will be based upon the applicable Blue Choice Options payment tier appropriate for that Provider. However, benefit payments for Covered Services rendered by Professional Providers in the PPO network, but not in the Blue Choice OPT PPO network will be based upon the Schedule of Maximum Allowances applicable to PPO network which these Providers have agreed to accept as payment in full (b) For Professional Providers Out-of-Network, the Maximum Allowance will be the lessor of (unless otherwise required by applicable law or arrangement with Out-of-Network Providers):

(i) the Provider's Billed Charges, or;

(ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 400% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Out-of-Network Professional Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Maximum Allowance for Out-of-Network Professional Providers will be 100% of the Claim Administrator's rate for such Covered Service according to its

current Schedule of Maximum Allowance. If there is no rate according to the Schedule of Maximum Allowance, then the Maximum Allowance will be 25% of Billed Charges.

The Claim Administrator will utilize the same Claim processing rules and/or edits, that it utilizes in processing Blue Choice Options and Participating Professional Provider Claims for processing Claims submitted by Out-of-Network Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY/MEDICAL NECESSITY.....means that a specific medical, health care, supply or Hospital service is required for the treatment or management of a medical symptom or condition, and that the service, supply, or care provided is the most efficient and economical service which can safely be provided.

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary, does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies. Please refer to the *Exclusions – What Is Not Covered* section of this booklet for additional information.

The Claim Administrator will make the initial decision whether hospitalization or other health care services or supplies were not Medically Necessary. In most instances this initial decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED. In making decisions of whether the hospitalization or other health care service(s) or supply(ies) are not Medically Necessary, and therefore not eligible for payment under the terms of this Plan, the Claim Administrator will take into account the information submitted to the Claim Administrator by your Provider(s), including any consultations with such Providers(s).

Hospitalization or other health care is not Medically Necessary when, applying the definition of Medical Necessary to the circumstances surrounding the hospitalization or other health care, it is determined that the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital, or some other setting without adversely affecting the patient's condition.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's initial decision, your benefit program provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against the Claim Administrator, either at law or in equity. To initiate your appeal, you must give the Claim Administrator written notice of your intention to do so as described in the *Claim Filing and Appeals Procedures* section of this booklet.

Below are some examples, not an exhaustive list, of hospitalization or other health care services and supplies that are not Medically Necessary:

1. Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
2. Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
3. Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
4. Hospitalization or admission to a Skilled Nursing Facility or Residential Treatment Center, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
5. The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

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 implemented 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.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-EMERGENCY FIXED-WING AMBULANCE TRANSPORTATION .....means Ambulance Transportation on a fixed-wing airplane from a Hospital emergency department, other health care facility or Inpatient setting to an equivalent or higher level of acuity facility when transportation is not needed due to an emergency situation. Non-Emergency Fixed-Wing Ambulance Transportation may be considered Medically Necessary when you require acute Inpatient care and services are not available at the originating facility and commercial air transport or safe discharge cannot occur. Non-Emergency Fixed-Wing Ambulance Transportation provided primarily for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this Health Care Plan.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist operating within the scope of their license.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist operating within the scope of their license.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider operating within the scope of their license.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment in which patients 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 is 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: The Claim Administrator 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 the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PEDIATRIC PALLIATIVE CARE.....means, for children under the age of 21, care focused on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Pediatric Palliative Care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person-centered and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness. Through early integration into the care plan for the seriously ill, palliative care improves quality of life for the patient and the family. Palliative care can be offered in all care settings and at any stage in a serious illness through collaboration of many types of care providers.

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

PHYSICAL THERAPIST.....means a duly licensed physical therapist operating within the scope of their license.

PHYSICAL THERAPY.....means the treatment of a disease, injury, or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches operating within the scope of their license.

PHYSICIAN ASSISTANT.....means a duly licensed Physician Assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of their license.

PODIATRIST.....means a duly licensed podiatrist operating within the scope of their license.

PRIOR AUTHORIZATION.....means a requirement that you must obtain authorization from the Claim Administrator before you receive certain types of Covered Services designated by the Claim Administrator.

PRIOR AUTHORIZATION or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Behavioral Health Unit for a determination of Medically Necessary care under this benefit booklet.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider operating within the scope of their license.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you and operating within the scope of such license.

An “Administrator Provider” means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Provider” means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A "Participating Provider" means an Administrator Hospital, Administrator facility or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in a Blue Choice program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A "Blue Choice Options Provider" means an Administrator Hospital or a Professional Provider that has been designated by the Claim Administrator to provide services to participants in the Blue Choice Options program.

A "Professional Provider" means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, or any Provider designated by the Claim Administrator.

A "Participating Prescription Drug Provider" means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or specialty drug Pharmacy which has entered into an agreement to provide pharmaceutical services to participants in the benefit program. A retail Participating Pharmacy may or may not be a select Participating Pharmacy as that term is used in the Vaccinations obtained through Participating Pharmacies section.

A "Non-Participating Prescription Drug Provider" means a Pharmacy, including but not limited to, an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which (i) has not entered into a written agreement with the Claim Administrator or (ii) has not entered into a written agreement with an entity chosen by the Claim Administrator to administer its prescription drug program, for such Pharmacy to provide pharmaceutical services at the time Covered Services to participants in the benefit program at the time Covered Services are rendered.

PROVIDER INCENTIVE.....means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed upon procedural and/or outcome measures for a particular population of participants.

PSYCHOLOGIST.....means a Registered Clinical Psychologist operating within the scope of such license.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois "Psychologists Registration Act" or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

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 post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

QUALIFIED ABA PROVIDER.....means a Provider operating within the scope of their license registration or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:

(i) Master's level, independently licensed Clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided, for services treating Autism Spectrum Disorder (ASD) symptoms, with or without applied behavior analysis (ABA) service techniques; or

(ii) Master's level Clinician whose professional credential is recognized and accepted by an appropriate agency of the United States (i.e., Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst-Doctoral (BCBA-D) to supervise and provide treatment planning, with ABA service techniques; or

(iii) Health Care Practitioner who is certified as a provider under the TRICARE military health system, if requesting to provide ABA services; or

(iv) Master's level Clinician with a specific professional credential or certification recognized by the state in which the clinician is located; or

1. Developmental Therapist with Certified Early Intervention Specialist credential or CEIS; or
2. If the Doctor or Medicine (MD) prescribes ABA, writes a MD order for services to be provided by a specific person.

For the para-professional/line therapist:

(i) Two years of college educated staff person with a Board-Certified Assistant Behavior Analyst (BCABA) for the para-professional/therapist; or

(ii) A bachelor level or high school graduate having obtained a GED, OR a staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist; or

(iii) A person who is "certified as a provider under TRICARE military health system," if requesting to provide ABA services.

RECOMMENDED CLINICAL REVIEW.....means an optional voluntary review of Provider's recommended medical procedure, treatment, or test, which does not require Prior Authorization, to make sure it meets approved Claim Administrator medical policy guidelines and Medical Necessity requirements.

REGISTERED DIETICIAN.....means a duly licensed clinical professional counselor operating within the scope of their license.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of their certification.

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 level of security, supervision, and structure medically necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with

24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

RESPITE CARE SERVICE.....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 to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

ROUTINE PATIENT COSTS.....means the cost for all items and services consistent with the coverage provided under this benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

(i) The investigational item, device, or service, itself;

(ii) 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

(iii) 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 and operating within the scope of such licenses.

An "Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill 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.

SPEECH THERAPIST.....means a duly licensed speech therapist operating within the scope of their license.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

STANDARD FERTILITY PRESERVATION SERVICES.....means procedure based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society for Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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 which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. 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 is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such license. 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.

An “Administrator Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility that does not meet the definition of an Administrator Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations, and any other procedures as reasonably approved by the Claim Administrator.

TELEHEALTH AND TELEMEDICINE SERVICES.....means a health care service delivered by a health care professional licensed, certified, or registered to practice in Illinois and acting within the scope of their license, certification, or entitlement to a patient at a different physical location than the health care professional using telecommunications or information technology.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves, and other tissues relating to that joint.

TOBACCO USER.....means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your Identification Card or visit our website at *www.bcbsil.com*.

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 a covered person other than an 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.

TRANSPLANT LODGING ELIGIBLE EXPENSE.....means the amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

VALUE BASED PROGRAM.....means an out-come based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

VIRTUAL PROVIDER.....means a licensed Provider who has a written agreement with the Claim Administrator to provide diagnosis and treatment of injuries and illnesses through either (i) interactive audio communication (via telephone or other similar technology) or (ii) interactive audio/video examination and communication (via online portal, mobile application, or similar technology) to you at the time Covered Services are rendered, operating within the scope of such license.

VIRTUAL VISIT.....means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the VIRTUAL VISITS provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

VITAMIN D TESTING....means vitamin D blood testing that measures the level of vitamin D in a person's blood.

ELIGIBILITY SECTION

This benefit booklet contains information about the health care benefit program for the persons who:

- Meet the definition of an Eligible Person: A full-time employee. A full-time employee is a person who is scheduled to work a minimum of 20 hours per week and who is on the permanent payroll of the Employer;
- Retirees according to IMRF. Age 55 Plus/Pension Eligible;
- Have applied for this coverage; and
- Have received an Identification Card.

If you meet this description and comply with the other terms and conditions of this benefit booklet, including, but not limited to, payment of premiums, you are entitled to the benefits of this program.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the ELIGIBILITY Section above and you are eligible for Medicare and not affected by the "Medicare Secondary Payer" (MSP) laws as described below, the benefits described in the section of this benefit booklet entitled "Benefits for Medicare Eligible covered persons" will apply to you and to your spouse and covered dependent children (if they are also eligible for Medicare and not affected by the MSP laws). This section does not apply to a party of a Civil Union with the Eligible Person and their children. This section does not apply to a Domestic Partner of the Eligible Person and their children.

A series of federal laws collectively referred to as the "Medicare Secondary Payer" (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the 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 the employer or whether the individual has "current employment status."
2. In the case of individuals aged 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).

3. 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 NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.

YOUR MSP RESPONSIBILITIES

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your employer 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 your employer or your group administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

YOUR ID CARD

You will receive an Identification Card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

FAMILY COVERAGE

Child(ren) used hereafter, means a natural child(ren), a stepchild(ren), an adopted child(ren), a child(ren) for whom you have received a court order requiring that you are financially responsible for providing coverage under 26 years of age, a child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care.

If you have Family Coverage, your health expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled children up to age 26 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 unless specifically noted otherwise. The coverage for children will end on the last day of the month in which the limiting age is reached.

Enrolled unmarried children will be covered up to age 30 if they:

- Live within the state of Illinois; 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.

Your enrolled Domestic Partner and their enrolled children who have not attained the limiting age stated above will be covered. Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions of this benefit booklet that pertain to a spouse also apply to a Domestic Partner, unless specifically noted otherwise.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

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 disabling condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO 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.
- Establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Birth, adoption, or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- 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 this coverage;
    b. The other coverage is not terminating for cause (such as failure to pay premiums or making 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 in this coverage.

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

a. Legal separation, divorce, dissolution from a Civil Union, cessation of dependent status, death of an employee, termination of employment, or reduction in the 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;

c. Reaching a lifetime limit on all benefits in another group health plan;

d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;

e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or

f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

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 31 days of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- 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 coverage 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 must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

Late Applicants

If you do not apply for Family Coverage or to add dependents within the required number of days of the event, you will have to wait until your Employer's annual open enrollment period to make those changes. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE OR VOLUNTARY TERMINATION OF INDIVIDUAL COERAGE

You may change from Family to Individual Coverage or Termination your Individual Coverage if you experience a qualifying life event as shown below:

- Death
- Divorce
- Marriage
- Eligibility for Medicare
- Birth, adoption or placement for adoption, or legal guardianship of a child
- The open enrollment opportunity under a spouse's plan (or the plan of the other parent of a covered dependent.)

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Health Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Health Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, their coverage will end as of the date the event occurs which makes them ineligible.

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

UTILIZATION MANAGEMENT AND REVIEW

The Claim Administrator has established the Utilization Management and Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on the Claim Administrator's Medical Policy and, site or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity review. If requested, services normally subject to a Post-Service Medical Necessity review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Please refer to the definition of Medically Necessary under the *Definitions* section of this booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

The Utilization Management and Review Program requires a review of the following Covered Services **before** maximum benefits for such services are available:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services
- Certain Outpatient Procedures

PRIOR AUTHORIZATION

Prior Authorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Services designated by the Claim Administrator in order to be eligible for maximum benefits.

For Inpatient Hospital facility services, your In-Network Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the In-Network Provider will be sanctioned based on the Claim Administrator's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about Prior Authorization for services outside of the Claim Administrator's service area, see the section of this benefit booklet entitled "THE BLUECARD PROGRAM."

Failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator, as described in this section, may result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles, and out-of-pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from

failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator. We encourage you to call ahead. The pre-notification toll-free telephone number is on your Identification Card.

Please read the provisions below very carefully. The provisions of this section do not apply to the treatment of Mental Illness and Substance Use Disorder Treatment. The provisions for the treatment of Mental Illness and Substance Use Disorder Treatment are specified in the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  Whenever a non-emergency or non-maternity Inpatient Hospital admission is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

  Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In the event of an emergency admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred.

- **Pregnancy/Maternity Admission Review**

  Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan.

  In the event of a maternity admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred.

Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

- **Skilled Nursing Facility Preadmission Review**

  Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Coordinated Home Care Program Preadmission Review**

  Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Private Duty Nursing Service Review**

  Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever Private Duty Nursing Service is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW

Outpatient Service Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever the following Outpatient procedure(s)/services(s), are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Coordinated Home Care Program services
- Home hemodialysis

- Home Hospice
- Home Infusion Therapy
- Home Health
- Private Duty Nursing
- Transplant Evaluations and Transplants
- Cardiology Lipid Apheresis

Ears, Nose and Throat (ENT):

- Bone Conduction Hearing Aids
- Cochlear Implant
- Nasal and Sinus Surgery

Gastroenterology (Stomach):

- Gastric Electrical Stimulation (GES)

Neurology:

- Deep Brain Stimulation
- Sacral Nerve Neuromodulation/Stimulation

Pain Management:

- Occipital Nerve Stimulation

Specialty Pharmacy:

- Specialty Pharmacy Medications covered by Medical Benefits including Infusion Site of Care, Medical Oncology & Supportive Care and Provider Administered Drug Therapies.

Surgical Procedures:

- Outpatient Surgery Jaw
- Outpatient Breast
- Surgical Deactivation of Headache Trigger Sites

Wound Care:

- Hyperbaric Oxygen (HBO2) Therapy-Systemic

Non-Emergency Fixed-Wing Ambulance Transportation:

Non-Emergency Fixed-Wing Ambulance Transportation - Please refer to the definition of "Non-Emergency Fixed-Wing Ambulance Transportation" under the DEFINITIONS section of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Whenever the following Outpatient services(s), received by a Non-Participating Provider, are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Dialysis
- Elective Surgery

If an Inpatient Emergency Hospital admission occurs after an Outpatient service, in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Claim Administrator.

The Claim Administrator will send a letter to you, your Physician and the Hospital or facility with a determination of your Prior Authorization review no later than fifteen (15) calendar days after the Claim Administrator receives the request for Prior Authorization review. However, in some instances depending on the timing of the request for review, these letters will not be received prior to your scheduled date of service or procedure.

For specific details about the Prior Authorization requirements for any of the above referenced Outpatient services, please call the customer service toll-free telephone number on the back of your Identification Card. The Claim Administrator reserves the right to no longer require Prior Authorization during your benefit period for any or all of the listed services. Updates to the list of services requiring Prior Authorization may be confirmed by calling the customer service number.

RECOMMENDED CLINICAL REVIEW

Some services that do not require Prior Authorization may be subject to review for evidence of medical necessity for coverage determinations that may occur prior to services rendered, during care, or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations where you have to pay for a non-approved service. The Claim Administrator will review the request to determine if it meets approved Claim Administrator medical policy and, site, or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbsil.com/find-care/where-you-go-matters/utilization-management for the Required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone

number on the back of your Identification Card. You or your Provider may request a Recommended Clinical Review.

Recommended Clinical Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions under this Plan. Please coordinate with your Provider to submit a written request for a Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

   A Recommended Clinical Review is not a guarantee of benefits or payment of benefits by the plan. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the member may have become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from the member's health care Provider or pharmacist. In addition to the written request for Recommended Clinical Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or Post-Service Claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms member eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

   A Post-Service Medical Necessity Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions,

limitations, and exclusions of this Certificate. Post-Service Medical Necessity Review does not guarantee payment of benefits by the plan, for instance a member may become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. Request for Additional Information

The Post-Service Medical Necessity Review process may require additional documentation from the member's health care Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the Inpatient or emergency admission review, the Claim Administrator will send a letter to you, your Physician, Provider of services, Behavioral Health Practitioner and/or the Hospital or facility with a determination on the approved length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to the Plan for continued services. If you, your Provider, or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an Ongoing Course of Treatment, the Plan will make a determination on the request/appeal as soon as possible but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS—WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator's Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION MANAGEMENT AND REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information, as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you, your Physician, Provider of health services, or Behavioral Health Practitioner disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your Identification Card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician, Provider of health services, or Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Blue Cross and Blue Shield of Illinois
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Management and Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Management and Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

The Claim Administrator's Behavioral Health Unit has been established to assist in the administration of Mental Illness and Substance Use Disorder Treatment benefits, including Prior Authorization review, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for your Inpatient Hospital admissions and/or Outpatient services for the treatment of Mental Illness and Substance Use Disorders.

Failure to contact the Behavioral Health Unit or to comply with the determinations of the Behavioral Health Unit, as described in this section, may result in a reduction of benefits. The Behavioral Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

Prior Authorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Services designated by the Claim Administrator in order to be eligible for maximum benefits.

For Inpatient Hospital facility services, your Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Claim Administrator's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about Prior Authorization for services outside of the Claim Administrator's service area, see the section of this benefit booklet entitled "THE BLUECARD PROGRAM."

Failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator, as described in this section, may result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles, and out-of-pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator. We encourage you to call ahead. The pre-notification toll-free telephone number is on your Identification Card.

CONTACTING BEHAVIORAL HEALTH

You, your Physician, Provider of services, or your authorized representative may contact the Claim Administrator for a Prior Authorization or Recommended Clinical Review by calling the toll-free number shown on the back of your Identification Card and follow the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Residential and Outpatient requests should be requested during regular business hours. After 6:00 PM, on weekends, and on holidays, the same

behavioral health line is answered by clinicians available for Inpatient acute reviews only.

PRIOR AUTHORIZATION REVIEW

- **Inpatient Hospital Prior Authorization Review**

  Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  To receive maximum benefits under this Health Care Plan, you must obtain Prior Authorization for your nonemergency Inpatient Hospital admission for the treatment of Mental Illness (other than Substance Use Disorder Treatments described below) by calling the Behavioral Health Unit. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. To determine if the Provider has completed the Prior Authorization requirements, you or someone on your behalf may call customer service at the toll-free number on your Identification Card. This call must be made at least one day prior to the Inpatient Hospital admission.

  Your Participating Provider, and not you, is required to obtain Prior Authorization for Inpatient Hospital admissions for Substance Use Disorder Treatment.

  For all other Non-Participating Providers, the Provider must notify the Claim Administrator within two business days after the initiation of Inpatient Hospital admissions for Substance Use Disorder Treatment, to the extent required by law. If your Provider does not notify the Claim Administrator, then you or someone on your behalf must notify the Claim Administrator within three business days of the initiation of Substance Use Disorder Treatment.

- **Residential Treatment Center Prior Authorization Review**

  Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness (other than Substance Use Disorder Treatments described below) is recommended by your Physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Behavioral Health Unit. This call must be made at least one day prior to scheduling of the admission. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization

requirements are satisfied, as described in this section. To determine if the Provider has completed the Prior Authorization requirements, you or someone on your behalf may call customer service at the toll-free number on your Identification Card. This call must be made at least one day prior to the Inpatient Hospital admission.

Your Participating Provider, and not you, is required to obtain Prior Authorization for Residential Treatment Center admissions for Substance Use Disorder Treatment.

For all other Non-Participating Providers, the Provider must notify the Claim Administrator within two business days after the initiation of Residential Treatment Center admissions for Substance Use Disorder Treatment, to the extent required by law. If your Provider does not notify the Claim Administrator, then you or someone on your behalf must notify the Claim Administrator within three business days of the initiation of Substance Use Disorder Treatment.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

  Emergency Mental Illness or Substance Use Disorder Admission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Behavioral Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness (other than Substance Use Disorder Treatments described below) has occurred.

  Your Participating Provider, and not you, is required to obtain Prior Authorization for Inpatient Hospital admissions for Substance Use Disorder Treatment.

  For all other Non-Participating Providers, the Provider must notify the Claim Administrator within two business days after the initiation of Inpatient Hospital admissions for Substance Use Disorder Treatment, to the extent required by law. If your Provider does not notify the Claim Administrator, then you or someone on your behalf must notify the Claim Administrator within three business days of the initiation of Substance Use Disorder Treatment.

  If the call is made any later than the specified time period, you may not be eligible for maximum benefits. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. To determine if the Provider has completed the Prior Authorization requirements, you or someone on your behalf may call customer service at the toll-free number on your Identification Card.

- **Partial Hospitalization Treatment Program Review**

  Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan, you must notify the Behavioral Health Unit no later than 48 hours after the admission for the treatment of Mental Illness (other than Substance Use Disorder Treatments described below) has occurred. Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied, as described in this section. To determine if the Provider has completed the Prior Authorization requirements, you or someone on your behalf may call customer service at the toll-free number on your Identification Card. The Behavioral Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

  Your Participating Provider, and not you, is required to obtain Prior Authorization for Partial Hospitalization Treatment Programs for Substance Use Disorder Treatment.

  For all other Non-Participating Providers, the Provider must notify the Claim Administrator within two business days after the initiation of Partial Hospitalization Treatment Programs for Substance Use Disorder Treatment, to the extent required by law. If your Provider does not notify the Claim Administrator, then you or someone on your behalf must notify the Claim Administrator within three business days of the initiation of Substance Use Disorder Treatment.

  If an Inpatient Emergency Mental Illness Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Behavioral Health Unit for an Emergency Mental Illness Admission Review.

- **Length of Stay/Service Review**

  Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Upon completion of the Prior Authorization or Emergency Mental Illness or Substance Use Disorder Review, the Behavioral Health Unit will send you a letter confirming that you or your representative called the Behavioral Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Behavioral Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will

not be extended, and the case will be referred to a Behavioral Health Unit Physician for review except as otherwise described in the APPEAL PROCEDURE section of this benefit booklet.

OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW

- **Outpatient Service Prior Authorization Review**

  Outpatient service Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  In order to receive maximum benefits under this Health Care Plan for Outpatient services for the treatment of Mental Illness or Substance Use Disorder, you must, except as otherwise provided, obtain Prior Authorization for the following Outpatient service(s) by calling the Behavioral Health Unit:

  - Psychological testing
  - Neuropsychological testing
  - Electroconvulsive therapy
  - Partial Hospitalization Program
  - Intensive Outpatient Programs (Please note, if your Provider of Substance Use Disorder Treatment notifies the Claim Administrator within two business days of the initiation of the service, you will not be required to Preauthorize).
  - Repetitive Transcranial Magnetic Stimulation
  - Applied Behavior Analysis (ABA) Therapies (Please see coverage details as described in the Autism Spectrum Disorder(s) provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.)

  Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the scheduling of the planned Outpatient services(s). The Behavioral Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

  If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after an Outpatient service, in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Behavioral Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission, Outpatient service, or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Behavioral Health Unit. If the Behavioral Health Unit concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, benefit for some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determinations, with a follow-up notification letter sent to you, your Behavioral Health Practitioner, and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Behavioral Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, "EXCLUSIONS—WHAT IS NOT COVERED."

The Behavioral Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Behavioral Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, Outpatient service or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Behavioral Health Unit determines that all or any portion of an Inpatient Hospital admission, Outpatient service, or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission, Outpatient service or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Behavioral Health Unit decides they were not Medically Necessary, except as otherwise provided in the APPEAL PROCEDURE section of this benefit booklet.

BEHAVIORAL HEALTH UNIT PROCEDURE

When you contact the Behavioral Health Unit to obtain Prior Authorization for your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Behavioral Health Unit to obtain Prior Authorization for your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Behavioral Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Providers in the area who may be able to provide the admission and/or services that are the subject of the Prior Authorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Behavioral Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Behavioral Health Unit and requesting an expedited appeal. The Behavioral Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Behavioral Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Behavioral Health Unit Physician, you may request an appeal in writing as outlined below.

If the Claim Administrator determines that Benefits, as defined below, related to Substance Use Disorder Treatment are no longer Medically Necessary, you or your authorized representative shall be notified in writing within 24 hours of the Adverse Determination of your right to request an external review. Because the denial was based on a medical judgment, you may have the right to an Independent External Review as described in INDEPENDENT EXTERNAL

REVIEW provision of the HOW TO FILE A CLAIM section of this benefit booklet.

You or your authorized representative may only request an expedited external review if initiated by submitting a request to the Illinois Department of Insurance as described in the EXPEDITED INDEPENDENT EXTERNAL REVIEW provision of the HOW TO FILE A CLAIM section of this benefit booklet, within 24 hours following the Adverse Determination notification from the Claim Administrator for Benefits related to Substance Use Disorder Treatment. Failure to request an expedited external review within 24 hours shall preclude you or your authorized representative from requesting an expedited external review. An expedited external review may not occur if the Substance Use Disorder Treatment Provider or facility determines that continued treatment is no longer Medically Necessary. For purposes of this section, "Benefits" means the benefits provided for treatment services for Inpatient and Outpatient treatment of Substance Use Disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.1 (Clinically Managed Low-Intensity Residential), 3.3 (Clinically Managed Population-Specific High-Intensity Residential), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services.

If an expedited external review request meets the criteria of the Health Carrier External Review Act, an independent review organization (IRO) shall make a final determination of Medical Necessity within 72 hours of the receipt of the request by the Claim Administrator. If an IRO upholds an Adverse Determination, the Claim Administrator will provide coverage of Benefits through the day following the determination of the IRO.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Behavioral Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within

30 days of the date you asked for a review. Also, during this 30-day period, you may review any relevant documents held by the Claim Administrator if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review, and you will be notified of this during the first 30-day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO OBTAIN PRIOR AUTHORIZATION OR NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Behavioral Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Behavioral Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

For Outpatient behavioral health services, including Partial Hospitalization Treatment Programs, there is no penalty to you for failure to notify the Claim Administrator. For Substance Use Disorder Treatment, there is no penalty to you for failure to notify the Claim Administrator for Inpatient Hospital admissions and Residential Treatment Centers.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

CASE MANAGEMENT

You may call the Behavioral Health Unit at the number shown on your Identification Card to access a case manager. They may answer questions about your behavioral condition, help you understand what to expect when you are discharged from a behavioral health facility to your home or to another care facility and help coordinate special care you may need. The behavioral health case management program is designed to help those with mental health and/or substance use concerns manage the unique challenges of those conditions. A case manager may reach out to you via phone or letter to offer case management assistance.

BENEFIT INFORMATION

Your employer has chosen a Claim Administrator Participating Provider Option benefit program for your Hospital and Physician benefits that provides you access to the Blue Choice PPO network. This program of health care benefits is designed to provide you with economic incentives for receiving Covered Services from a Blue Choice Options Provider.

As a participant in this benefit program, a directory of Providers participating in the Blue Choice PPO network will be available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at *www.bcbsil.com* for a list of Participating Providers. While there may be changes in the network list from time to time, selection of Providers by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location, and cost-effectiveness of care. Notice of changes in the network will be provided to your Group Administrator annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under this benefit program will be greater when you receive services from a Blue Choice Options Provider.

This section of your benefit booklet tells you what services are covered and how much will be paid. Your benefits are id for each of these services.

Your benefits are subject to all of the terms and conditions of this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits for the Covered Services described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

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

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

When you choose to use the services of a Blue Choice Options Provider, your deductible will be less than when you use another Provider. Each benefit period

you must satisfy a $1,000 deductible for Covered Services rendered by Blue Choice Options Provider(s). This deductible will be referred to as the program deductible.

Expenses incurred by you for Covered Services rendered by a Blue Choice Options Provider which are applied toward the Blue Choice Options Provider program deductible will also be applied toward the Participating Provider program deductible.

For Covered Services you receive from a Provider other than a Blue Choice Options Provider, the program deductible will be as stated below.

Each benefit period you must satisfy a $2,500 deductible for Covered Services rendered by a Participating Provider and a separate $5,000 deductible for Covered Services Out-of-Network or from Non-Administrator Provider(s). In other words, after you have Claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

Expenses incurred by you for Covered Services rendered by a Participating Provider which are applied toward the Participating Provider program deductible will also be applied toward the Blue Choice Options program deductible.

If you have any expenses for Covered Services during the last three months of a benefit period which were or could have been applied to that benefit period's program deductible, these expenses may be applied toward the program deductible of the next benefit period.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the program deductible amount of $3,000 for Covered Services rendered by a Blue Choice Options Provider, it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible before receiving benefits.

If you have Family Coverage and your family has reached the program deductible amount of $7,500 for Covered Services rendered by a Participating Provider and a separate $15,000 program deductible for Covered Services Out-of-Network or from Non-Plan Provider(s), it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member 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.

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.

HOSPITAL BENEFIT SECTION

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board, and general nursing care when you are in:
   — a semi-private room
   — a private room
   — an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings, and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Coordinated Home Care Program

Benefits will be provided for services under a Coordinated Home Care Program.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Blue Choice Options Provider

When you receive Inpatient Hospital Covered Services from a Blue Choice Options Provider or in a Plan Program of a Blue Choice Options Provider, benefits will be provided at 90% of the Eligible Charge after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds. If a private room is medically necessary, benefits will be based on the Hospital's private room and board rate.

For Inpatient Hospital Covered Services you receive at a Hospital other than a Blue Choice Options Provider, benefit payment will be as described below.

Participating Provider

When you receive Inpatient Hospital Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 70% of the Eligible Charge after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Out-of-Network

When you receive Inpatient Covered Services Out-of-Network, benefits will be provided at 50% of the Eligible Charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.

Benefits for an Inpatient Hospital admission Out-of-Network or to a Non-Plan Provider resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level which you would have received had you been in a Participating Hospital for that portion of your Inpatient Hospital stay during which your Medically Necessary condition is determined to be serious and therefore not permitting your safe transfer to a Participating Hospital or other Participating Provider.

Benefits for an Inpatient Hospital admission Out-of-Network or to a Non-Plan Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Out-of-Network Hospital payment level or the Non-Plan Hospital payment level (depending on the type of Provider) for that portion of your Inpatient Hospital stay during which your Medically Necessary condition is determined not to be serious and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

In order for you to continue to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Administrator or an Out-of-Network Hospital, you must transfer to a Participating Provider as soon as your condition is no longer serious.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery. In addition, benefits for Covered Services received for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.

   In addition to Surgery performed in a Hospital, benefits will be provided for Outpatient Surgery performed in an Ambulatory Surgical Facility.
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy

5. Partial Hospitalization Program
6. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
7. Diagnostic Service—when you are an Outpatient, and these services are related to Surgery or Medical Care
8. Urgent Care
9. Emergency Accident Care
10. Emergency Medical Care
11. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis
12. 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 that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Blue Choice Options Provider

Benefits will be provided at 90% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Blue Choice Options Provider.

Benefits for urgent care from a Blue Choice Options Provider will be provided at 100% of the Hospital's Eligible Charge, subject to a Copayment of $50 per visit. Your program deductible will not apply.

For Outpatient Hospital Covered Services you receive at a Hospital other than a Blue Choice Options Provider, benefit payment will be as described below.

Participating Provider

Benefits will be provided at 70% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Benefits for urgent care from a Participating Provider will be provided at 100% of the Hospital's Eligible Charge, subject to a Copayment of $50 per visit. Your program deductible will not apply.

Out-of-Network

When you receive Outpatient Hospital Covered Services Out-of-Network, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.

Benefits for urgent care from a Participating Provider will be provided at 50% of the Hospital's Eligible Charge, after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Administrator Provider will be paid at the same payment level which would have been paid had such services been received from a Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 90% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Accident Care either, from a Blue Choice Options, a Participating, Out-of-Network or Non-Administrative Provider in a Hospital emergency room department. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Accident Care will be subject to the Participating Provider program deductible.

Benefits for Emergency Medical Care will be provided at 90% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Medical Care either from a Blue Choice Options, a Participating, Out-of-Network or Non-Plan Provider.

Benefits for Emergency Medical Care will be subject to the Participating Provider program deductible.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.

If you disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Accident Care or Emergency Medical Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet for specific information on your right to seek and obtain a full and fair review of your Claim.

WHEN SERVICES ARE NOT AVAILABLE FROM A BLUE CHOICE OPTIONS PROVIDER OR PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Blue Choice Options provider or a Participating Provider, benefits for the Covered Services you receive from a Provider Out-of-Network will be provided at the payment level described for a Participating Provider.

PHYSICIAN AND OTHER PROFESSIONAL SERVICES

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

Certain services are covered pursuant to the Claim Administrator's medical policies and clinical procedure and coding policies, which are updated throughout the Calendar Year. The medical policies are guides considered by the Claim Administrator when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the benefit Plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsil.com, or call customer service at the number listed on the back of your Identification Card.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them, and which would be payable under this benefit booklet had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth and;
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:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for Anesthesia Services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

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, 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 19 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.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery when performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are voluntary).

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

A1C Testing

This plan provides benefits for A1C testing for prediabetes, type I diabetes, and type II diabetes mellitus.

Biomarker Testing

This plan provides benefits for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition, including Medically Necessary home saliva cancer screenings, once every twenty-four (24) months, if you are at high risk or showing symptoms of the disease being tested for.

Biomarker Testing means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. The term includes single-analyte tests, multiplex panel tests and whole genome sequencing.

Blood Glucose Monitors for Treatment of Diabetes

This plan provides benefits for Medically Necessary blood glucose monitors (including continuous glucose monitors, non-invasive monitors and monitors for the blind) if a Physician has provided a written order. This coverage also includes related supplies, and training in the use of continuous glucose monitors.

Benefits for glucose monitors will be provided at no charge when obtained from a Participating Provider.

Comprehensive Cancer Testing

This plan provides benefits 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.

Pancreatic Cancer Screening

This plan provides benefits for Medically Necessary pancreatic cancer screenings.

Vitamin D Testing

This plan provides benefits for Vitamin D Testing in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention.

Medical Benefit Therapeutic Alternatives

Certain prescription drugs administered by a health care professional have therapeutic equivalents or therapeutic alternatives that are used to treat the same condition. Benefits may be limited to only certain therapeutic equivalents or

therapeutic alternatives. However, benefits may be provided for the therapeutic equivalents or therapeutic alternatives that are not otherwise covered under your benefit, if an exception is granted.

You may contact Customer Service at the toll-free telephone number on the back of your Identification Card or visit www.bcbsil.com/find-care/medical-rx for more information about covered therapeutic equivalents or therapeutic alternatives. To request an exception, you, your prescribing health care Provider, or your authorized representative, can call the toll-free telephone number on the back of your Identification Card.

Therapeutic equivalents or therapeutic alternatives may be covered through your prescription drug benefit, depending on your benefit plan.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, a Residential Treatment Center, or Substance Use Disorder Treatment Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office, or your Physician comes to your home.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education, and medical nutrition therapy. Benefits will be provided for education programs that allow you to maintain a hemoglobin A1C level within the ranges 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, operating within the scope of their license. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Orthopedic Shoes—Benefits will be provided for orthopedic shoes when prescribed by a Physician. Your benefits will be limited to one pair (maximum of two total) of shoes per benefit period.

Elastic Support Stockings—Benefits will be provided for elastic support stockings when prescribed by a Physician. Your benefits will be limited to one per benefit period.

Emergency Accident Care

Emergency Medical Care

Electroconvulsive Therapy

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Occupational Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a licensed professional Physical Therapist; provided, however, when the therapy is beyond the scope of the Physical Therapist's license, the Physical Therapist must be under the supervision of a Physician, and the therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Physical Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

Chiropractic and Osteopathic Manipulations—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulations, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulations will be limited to a maximum of 75 visits per benefit period.

Radiation Therapy Treatments

This plan provides benefits for Medically Necessary radiation therapy treatments.

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Speech Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

Telehealth and Telemedicine Services

This plan provides benefits for Telehealth and Telemedicine Services as defined under the BENEFIT HIGHLIGHTS and DEFINITIONS section of this booklet.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician. Benefits for clinical breast examinations will be provided at the benefit payment level described under the Preventive Care Services provision in the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

Breast Reduction Surgery

This Plan provides benefits for Medically Necessary breast reduction surgery.

Diagnostic Colonoscopies

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

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/or your Physician are encouraged to call customer service at

the toll-free number on your Identification Card in advance to obtain information about whether a particular clinical trial is qualified.

Ovarian Cancer Screening

Benefits will be provided for annual ovarian cancer screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or pap smear test.

Prostate Cancer Screening

Benefits will be provided for an annual routine prostate cancer screening.

Routine Liver Screening

Benefits will be provided at no charge for routine liver screenings, including liver ultrasounds and alpha-fetoprotein blood tests, for individuals who are at high risk for liver disease, every six months.

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

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 that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Durable Medical Equipment

Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), compression sleeves to prevent or mitigate lymphedema, bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by the Claim Administrator. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Orthotic Devices

Benefits will be provided for 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 Medically Necessary.

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, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances, and surgical implants 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.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances and replacement of cataract lenses when a prescription change is not required).

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants, and Outpatient contraceptive services. Outpatient contraceptive services means consultations, 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.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

Tobacco Cessation Drugs—Benefits will be provided for Smoking Cessation drugs limited to a maximum of two 90 days treatment regimens per benefit period.

Reconstructive Services

This plan provides benefits for Medically Necessary reconstructive services to restore physical appearance due to trauma.

Growth Hormone Therapy

Gender assignment surgery and gender reassignment surgery with related services.

Hormone Therapy to Treat Menopause

This plan provides benefits for Medically Necessary hormone therapy to treat menopause that has been induced by a hysterectomy.

Hormone Therapies to Treat Menopause

This plan provides benefits for Medically Necessary hormonal and non-hormonal treatments for menopausal symptoms, including all FDA approved administration modalities such as oral, transdermal, topical, and vaginal rings.

Mobile Integrated Health Care Services

Benefits will be provided for Medically Necessary health services provided on-site by emergency medical services personnel, when your Provider has determined such services would likely prevent admission or readmission to a hospital, behavioral health facility, acute care facility, or nursing facility.

Inherited Gene Mutation Testing

Benefits will be provided for outpatient clinical genetic testing for an inherited gene mutation for those with a personal or family history of cancer, or for evidence-based screenings for those with an inherited mutation, associated with an increased risk of cancer, when recommended by a Provider. Cost sharing for this coverage will not exceed $50 per test, when obtained from a Participating Provider.

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

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 Certificate, 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 Mental Health to deliver coordinated specialty care for first episode psychosis treatment.

Routine Pediatric Hearing Examination—Benefits will be provided for routine hearing examinations.

Pulmonary Rehabilitation Therapy—Benefits will be provided for Outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and Outpatient pulmonary rehabilitation services.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Blue Choice Options, Participating or Out-of-Network Professional Provider. In most cases, your benefits will be greater when you receive services from a Blue Choice Options Provider.

Blue Choice Options Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Blue Choice Options Professional Provider or from a Dentist, benefits will be provided at 90% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this Certificate.

When you receive Covered Services (except for those services specified below) in a Blue Choice Options Professional Provider's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to a Copayment of $25 per visit. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services (except for those services specified below) in a Blue Choice Options Professional Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to a Copayment of $50 per visit. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

A specialist is a Provider who is **not** a:

- Behavioral Health Practitioner
- Certified Nurse-Midwife
- Certified Nurse Practitioner
- Certified Clinical Nurse Specialist
- Clinical Professional Counselor
- Clinical Social Worker
- Clinical Laboratory
- Marriage and Family Therapist
- Mixed psychiatric group
- Mixed specialty group
- Neuro Psychologist
- Optician

- Optometrist
- Retail Health Clinic

or a Physician in:

- clinical psychology
- family practice
- general practice
- gynecology
- internal medicine
- obstetrics
- obstetrics/gynecology
- pediatrics
- psychiatry

The following Covered Services are not subject to the Blue Choice Options office visit Copayment, and benefits will be provided at the general medical/surgical payment level, unless otherwise specified in this benefit booklet:

- Surgery
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Chiropractic and osteopathic manipulation

When you receive Covered Services, from a Blue Choice Options Hospital or from an Administrator Ambulatory Surgical Facility and, due to any reason, Covered Services are provided by an anesthesiologist (including a Certified Registered Nurse Anesthetist,) pathologist, radiologist, neonatologist, emergency room Physician, assistant surgeon (if the primary surgeon is a Participating Provider) or other Physician who is not a Participating Provider, are unavailable from a Blue Choice Options Provider and Covered Services are provided by an Out-of-Network Provider, you will incur no greater out-of-pocket costs than you would have incurred if the Covered Services were provided by a Participating Provider.

However, in the event that you willfully choose to receive Covered Services from an Out-of-Network Provider when a Participating Professional Provider is available, or you or the Out-of-Network Provider reject the assignment of benefits, the above provision will not apply to you.

For Physician Covered Services you receive from a Provider other than a Blue Choice Options Provider, benefit payment will be as described below.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 70% of the Maximum Allowance after you have met your program deductible. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

When you receive Covered Services (except for those services specified below) in a Participating Provider's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to a Copayment of $50 per visit. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services (except for those services specified below) in a Participating Provider specialist's office, benefits for Covered Services are subject to a Copayment of $100 per visit. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

A specialist is a Provider who is **not** a:

- Behavioral Health Practitioner
- Certified Nurse-Midwife
- Certified Nurse Practitioner
- Certified Clinical Nurse Specialist
- Clinical Professional Counselor
- Clinical Social Worker
- Clinical Laboratory
- Marriage and Family Therapist
- Mixed psychiatric group
- Mixed specialty group
- Neuro Psychologist
- Optician
- Optometrist
- Retail Health Clinic

or a Physician in:

- clinical psychology
- family practice
- general practice
- gynecology

- internal medicine
- obstetrics
- obstetrics/gynecology
- pediatrics
- psychiatry

The following Covered Services are not subject to the Participating Provider office visit Copayment, and benefits will be provided at the general medical/surgical payment level, unless otherwise specified in this benefit booklet:

- Surgery
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Chiropractic and osteopathic manipulation

When you receive tobacco cessation drugs from a Participating Provider, benefits will be provided at 100% of the Maximum Allowance and your program deductible will not apply. Benefits will be provided for prescription or over-the-counter tobacco cessation drugs.

When you receive Covered Services, from a Participating Hospital or from a Plan Ambulatory Surgical Facility and, due to any reason, Covered Services for anesthesiology, pathology, radiology, neonatology or emergency room are unavailable from a Participating Provider and Covered Services are provided by an Out-of-Network Provider, you will incur no greater out-of-pocket costs than you would have incurred if the Covered Services were provided by a Participating Provider.

However, in the event that you willfully choose to receive Covered Services from an Out-of-Network Provider when a Participating Professional Provider is available, or you or the Out-of-Network Provider reject the assignment of benefits, the above provision will not apply to you.

Out-of-Network

When you receive any of the Covered Services described in this Physician Benefit Section from a Professional Provider Out-of-Network, benefits will be provided at 50% of the Maximum Allowance, after you have met your program deductible, unless specifically mentioned below.

Emergency Care

Benefits for Emergency Accident Care will be provided at 90% of the Maximum Allowance when rendered by either a Blue Choice Options, Participating or Out-of-Network Provider after you have met your Participating Provider program deductible. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services

will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Medical Care will be provided at 90% of the Maximum Allowance when rendered by either a Blue Choice Options, Participating or Out-of-Network Provider after you have met your Participating Provider program deductible.

If you disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Accident Care or Emergency Medical Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet for specific information on your right to seek and obtain a full and fair review of your Claim.

Participating and Non-Participating Professional Providers are:

- Acupuncturists
- Audiologists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Dentists*
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Naprapaths
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Other Professional Providers
- Physical Therapists
- Physicians
- Podiatrists
- Psychologists
- Prosthetic Providers
- Registered Surgical Assistants
- Registered Dieticians
- Retail Health Clinics
- Speech Therapists

* Dentists are Non-Participating Providers, and will be treated as such for purposes of benefit payment made under this benefit booklet. They may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

Participating Providers have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Professional Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Professional Provider is a Participating Professional Provider, contact your Employer, your Professional Provider, or the Claim Administrator.

OTHER COVERED SERVICES

OTHER COVERED SERVICES

This section of your benefit booklet describes "Other Covered Services" and the benefits that will be provided for them.

- The processing, transporting, blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration.
- Medical and surgical dressings, supplies, casts, and splints.
- Hearing Implants—Benefits will be provided for bone anchored Hearing Aids and cochlear implants.
- Hearing Aids—Benefits will be provided for Medically Necessary Hearing Aids when a Hearing Care Professional prescribes a Hearing Aid to augment communication as follows:
    - (i) Benefits for one Hearing Aid will be covered for each ear every 24 months;
    - (ii) Related services, such as audiological examinations and selection, fitting, and adjustment of ear molds to maintain optimal fit will be covered when deemed Medically Necessary by a Hearing Care Professional; and
    - (iii) Hearing Aid repairs will be covered when deemed Medically Necessary.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 90% of the Eligible Charge or 90% of the Maximum Allowance for any of the Covered Services described in this section.

Benefits for ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility) will be provided at 90% of the Eligible Charge or 90% of the Maximum Allowance after you have met your program deductible.

Notwithstanding anything else described herein, Providers of ambulance services will be paid based on the amount that represents the billed charges from the majority of the ambulance Providers in the Chicago Metro area, as submitted to the Claim Administrator. Benefits for Ambulance Transportation will be paid at the highest level available under this benefit program. However, you will be responsible for any charges in excess of this amount.

Participating and Non-Participating Professional Providers are:

- Acupuncturists
- Audiologists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Dentists*
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Naprapaths
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Other Professional Providers
- Physical Therapists
- Physicians
- Podiatrists
- Psychologists
- Prosthetic Providers
- Registered Surgical Assistants
- Registered Dieticians
- Retail Health Clinics
- Speech Therapists

* Dentists are Non-Participating Providers, and will be treated as such for purposes of benefit payment made under this benefit booklet. They may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

When you receive Other Covered Services from either a Blue Choice Options, Participating or Out-of-Network Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

The expenses that are your responsibility for your Other Covered Services will depend on whether you receive services from a Blue Choice Options, Participating or Out-of-Network Provider.

Participating Providers have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Professional Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Professional Provider is a Participating Professional Provider, contact your Employer, your Professional Provider, or the Claim Administrator.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have the Claim Administrator coverage each will have their benefits paid by their own the Claim Administrator program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation, and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants will be provided as follows:

- **Whenever a heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.**
- Your benefits under this coverage will begin no earlier than 5 days prior to the transplant Surgery and shall continue for a period of no longer than 365 days after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.

— If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and one or two companion(s). 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:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
- Meals.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in the Claim Administrator approved programs. 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.

PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided for in this benefit booklet, (and notwithstanding anything in your benefit booklet to the contrary), the following preventive care services will be considered Covered Services and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum (to be implemented in the quantities and within the time period allowed under applicable law or regulatory guidance) when such services are received from a Blue Choice Options or Participating Provider or Participating Pharmacy that is contracted for such service:

- 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");

- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
- 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;
- 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; and
- Preventive Drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive 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 No-Cost Preventive Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.

A copay waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List. Please call the Customer Service toll-free telephone number on the back of your Identification Card for more information or visit BCBSIL.com/provider or myprime.com to obtain a Copay waiver form.

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 Preventive Care Services benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described in items 1. through 5. above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Claim Administrator's Web site 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, including but not limited to, those related to setting and medical appropriateness to determine coverage.

If a covered preventive health service is provided during the office visit and is billed separately from the office visit, you may be responsible for the Copayment or Coinsurance 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 or Coinsurance 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 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):
    - Haemophilus influenzae type b (Hib)
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster (Shingles)
    - Human papillomavirus
    - Influenza (Flu shot or flu mist)
    - Measles, Mumps, Rubella
    - Meningococcal
    - MPOX
    - Pneumococcal
    - RSV
    - Tetanus, Diphtheria, Pertussis (DTap/Tdap/Td)
    - 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 interventions to prevent falls in adults aged 65 years and older who are at increased risk for falls
18. Hepatitis C virus (HCV) screening of infection in adults aged 19 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 aged 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 risk of tuberculosis
26. Whole body skin examination for lesions suspicious for skin cancer

Preventive Care Services for Women (including pregnant women or 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
4. Breast cancer chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive lactation 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 benefit period.
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, not including abortifacient drugs

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

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 members
5. Congenital hypothyroidism screening for newborns
6. Critical congenital heart defect screening for newborns
7. Depression screening for adolescents
8. Development screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children ages 9-11 and 17-21
10. Bilirubin screening in newborns
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish to 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 (HPV)
    - Influenza (Flu shot or Flu mist)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Varicella
    - Haemophilus influenzae type b (Hib)
    - Rotavirus
    - RSV

- Inactivated Poliovirus
- Diphtheria, Tetanus, Pertussis (DTap/Tdap/Td)
- COVID-19

20. Lead screening for children at risk for exposure
21. Medical history for all children throughout development
22. Obesity screening and counseling
23. Oral health risk assessment for younger children up to six years old
24. Phenylketonuria (PKU) screening for newborns
25. Sexually transmitted infections (STI) prevention and counseling for adolescents
26. Tuberculin testing for children at higher risk of tuberculosis
27. Vision screening for children and adolescents
28. Autism screening
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 Drug List*. This list is available on the Claim Administrator's website at *www.bcbsil.com* and/ or by contacting customer service at the toll-free number on your Identification Card. Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the *Contraceptive Drug List*. You may, however, have coverage under other sections of this benefit booklet, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The *Contraceptive Drug 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.

Routine pediatric care, preventive care (such as contraceptives) and/or Outpatient periodic health examinations Covered Services not included above will be subject to the deductible, Coinsurance, Copayments and/or benefit maximums previously described in this benefit booklet, if applicable.

Preventive care services received from a Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other routine Covered Services not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximums.

Benefits for vaccinations that are considered preventive care services will not be subject to any deductible, Coinsurance, Copayments and/or benefit maximum when such services are received from a Blue Choice Options or Participating Provider or Participating Pharmacy.

Benefits for vaccinations that are considered preventive care services will not be subject to any deductible, Coinsurance, Copayments and/or benefit maximum when such services are received from a Community or Participating Provider or Participating Pharmacy.

Vaccinations that are received from a Out-of-Network Provider Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other vaccinations that are not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximum.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

- Routine diagnostic medical procedures;
- Routine laboratory tests;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray;
- Routine digital rectal examinations and prostate tests.

In-Network

Benefits for wellness care In-Network will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Out-of-Network

Benefits for wellness care Out-of-Network will be provided at 50% of the Eligible Charge or 50% of the Maximum Allowance and will not be subject to the program deductible.

ROUTINE MAMMOGRAMS

Benefits will be provided for routine mammograms. 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 by their Physician.

If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening and magnetic resonance imaging (MRI) screening of an entire breast or breasts, when determined to be Medically Necessary by your Physician.

DIAGNOSTIC MAMMOGRAMS

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

Blue Choice Options Provider

Benefits for routine mammograms when rendered by a Blue Choice Options Provider will be provided at 100% of the Eligible Charge or Maximum Allowance whether or not you have met your program deductible. Benefits for routine mammograms rendered by a Blue Choice Options Provider will not be subject to the Physician office visit Copayment.

Participating Provider

Benefits for routine mammograms when rendered by a Participating Provider will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance whether or not you have met your program deductible.

Out-of-Network Provider

Benefits for routine mammograms when rendered by an Out-of-Network Provider will be provided at 50% of the Eligible Charge or 50% of the Maximum Allowance after you have met your program deductible. Benefits for routine mammograms will not be subject to the Out-of-Network Provider office visit Copayment if applicable.

Benefit Maximum

Benefits for routine mammograms will not be subject to any benefit period maximum or lifetime maximum.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board, and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 70% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 50% of the Eligible Charge once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefit payment for Covered Services rendered by an Administrator Ambulatory Surgical Facility will be provided at the same payment level as Blue Choice Options Hospital Outpatient Surgery. Benefits for services by a Non-Administrative Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 70% of the Eligible Charge. Benefits for services by a Non-Administrator Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

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 (a) by a Physician or a Psychologist who has determined that such care is Medically Necessary, or (b) by a certified, registered or licensed health care professional with expertise in treating Autism Spectrum Disorder(s), including but not limited to, a health care professional who is eligible as a Qualified ABA Provider by state regulation and when such care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:

- psychiatric care, including diagnostic services;
- psychological assessments and treatments;
- habilitative or rehabilitative treatments;
- therapeutic care, including behavioral Speech, Occupational and Physical 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.

Please review the Occupational Therapy, Physical Therapy and Speech Therapy provisions in this benefit booklet.

Note: Covered benefits for clinically appropriate Autism Spectrum Disorder services and Habilitative services will not be denied solely on the basis of where those services are provided.

HABILITATIVE SERVICES

Your benefits for Habilitative Services with Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all of the following conditions are met:

- a physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
- treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, or Psychologist upon the referral of a Physician; and
- treatment must be Medically Necessary and therapeutic and not Investigational.

SUBSTANCE USE DISORDER TREATMENT

Benefits for all of the Covered Services previously described in this benefit booklet are available for Substance Use Disorder Treatment. In addition, benefits will be provided if these services are rendered by a Substance Use Disorder Treatment Facility. Benefits will be provided at the payment levels described later in this benefit booklet. Substance Use Disorder treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Administrator Provider facility payment level described later in this benefit section.

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 section of this benefit booklet, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance

Use Disorder. Benefits for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder includes pregnancy and postpartum periods and are available for those who have experienced a miscarriage or stillbirth. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness or Substance Use Disorder in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

BARIATRIC SURGERY

Benefits for Covered Services received for bariatric Surgery will be provided under the HOSPITAL BENEFIT and PHYSICIAN BENEFIT sections of this benefit booklet, the same as for any other condition.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. (If the newborn child needs treatment for an illness, injury, congenital defect (including Medically Necessary treatment of cleft lip and palate), birth abnormalities, and premature birth, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the birthing parent or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours). Such an earlier discharge may only be provided if there is coverage and availability of a post-discharge Physician office visit or an in-home visit to verify the condition of the infant in the first 48 hours after discharge.

Other Reproductive Health Services

Your coverage includes benefits for abortion care. Benefits for abortion care are the same as your benefits for any other condition.

Your coverage includes benefits for abortion care. Benefits for abortion care will be provided at no cost.

FERTILITYCARE

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of Infertility, or to promote fertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, surgical sperm extraction procedures, low tubal ovum transfer and intracytoplasmic sperm injection. This coverage also includes procedures necessary to screen or diagnose a fertilized egg, before implantation, for aneuploidy, chromosome structural rearrangements, and monogenic or single gene disorders.

Benefits for the diagnosis and/or treatment of infertility described above are subject to the following conditions:

1. They are determined to be Medically Necessary by your Provider, based on clinical guidelines and standards developed by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the Society for Assisted Reproductive Technology; and
2. They are performed at Facilities that are members in good standing of the Society for Assisted Reproductive Technology.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy. The one year requirement will be waived if your Physician determines a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means a sexual union 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 Infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless. Benefits for treatments that include oocyte retrievals will be unlimited. Coverage includes medical expenses for donor for the retrieval and transfer only.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure 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.

Special Limitations

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm, or embryos from you will be covered if you choose to use a surrogate.
2. Expenses incurred for 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 SERVICES provision of this benefit booklet.
3. Non-medical costs of an egg or sperm donor.
4. Fertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
5. Fertility treatment rendered to your dependents under age 18.

FERTILITY PRESERVATION SERVICES

Your benefits for fertility preservation services are the same as your benefits for any other condition. Benefits will be provided for Medically Necessary Standard Fertility Preservation Services when a Medically Necessary treatment may directly or indirectly cause Iatrogenic Infertility to you.

For purposes of this section, Iatrogenic Infertility means an impairment of fertility caused directly or indirectly by surgery, radiation, chemotherapy, or other medical treatment, affecting reproductive organs or processes.

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.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are 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. Inpatient care following a mastectomy for the length of time determined by your 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 48 hours after discharge;
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; and
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 is not considered Cosmetic Surgery.

VIRTUAL VISITS

Benefits will be provided for Covered Services described in this benefit booklet for the diagnosis and treatment of non-emergency medical and/or behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit. Benefits for such Covered Services will only be provided if you receive them via consultation with a Virtual Provider who has a specific written agreement with the Claim Administrator to provide Virtual Visits to you at the time services are rendered. For more information about this benefit, you may visit the Claim Administrator's website at *www.bcbsil.com* or call customer service at the number on the back of your Identification Card.

Benefits for Covered Services you receive through a Virtual Visit from an In-Network Virtual Provider are subject to the same office visit Copayment as indicated for Providers as described under the BENEFIT PAYMENT FOR PHYSICIAN SERVICES provision in the PHYSICIAN BENEFIT SECTION of this benefit booklet.

Benefits will not be provided for services you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with the Claim Administrator to provide Virtual Visits.

Note: Not all medical or behavioral health conditions can be appropriately treated through Virtual Visits. The Virtual Provider will identify any condition for which treatment by an in-person Provider is necessary.

PAYMENT PROVISIONS

Lifetime Maximum

Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Blue Choice Options Providers, Participating Providers, and Out-of-Network Providers.

For Blue Choice Options Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $2,500, any additional Eligible Claims for Blue Choice Options Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for which you are responsible after benefits have been provided

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services received Out-of-Network or rendered by a Non-Administrator Provider
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Claim Administrator's Behavioral Health Unit

If you have Family Coverage and your out-of-pocket expense as described above equals $5,500 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $5,500, any additional eligible claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for which you are responsible after benefits have been provided

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services received Out-of-Network or rendered by a Non-Plan Provider
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Behavioral Health Unit

If you have Family Coverage and your out-of-pocket expense as described above equals $10,200 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

For Out-of-Network Providers

If, during one benefit period, your Out-of-Network out-of-pocket expense (the amount remaining unpaid after Out-of-Network benefits have been provided) equals $11,000, any additional eligible Out-of-Network Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for Covered Services received Out-of-Network for which you are responsible after benefits have been provided

The following expenses for Covered Services cannot be applied to the Out-of-Network out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your Out-of-Network out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance

- the Coinsurance resulting from Covered Services you may receive from a Blue Choice Options Provider
- the Coinsurance resulting from Covered Services you may receive from a Participating Provider
- the Coinsurance resulting from Hospital services rendered by a Non-Plan Hospital or other Non-Plan Provider facility for Covered Services
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Behavioral Health Unit
- any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period

If you have Family Coverage and your Out-of-Network out-of-pocket expense as described above equals $26,400 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient in a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Residential Treatment Center or a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program at the time your coverage under this benefit booklet is terminated, benefits will be provided for, and limited to, the Covered Services under this benefit booklet until you are discharged or until the end of your benefit period, whichever occurs first.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you 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 attending Physician, 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;
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 Service.

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.

Pediatric Palliative Care

This Plan also provides benefits for Pediatric Palliative Care, for children under the age of 21 with a serious illness, by a trained interdisciplinary team that allows a child to receive community-based Pediatric Palliative Care, while continuing to pursue curative treatment and disease-directed therapies for the qualifying illness.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

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 under this Benefit Section only includes benefits for drugs and supplies which are self-administered; however, 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, your benefit for drugs and supplies will be greater when you purchase them from a Participating Pharmacy. You can visit the Claim Administrator's website at *www.bcbsil.com* for a list of Participating Pharmacies. The Pharmacies that are Participating Prescription Drug Pharmacies may change from time to time. You should check with your Pharmacy before purchasing 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 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, Preferred 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:

AVERAGE WHOLESALE PRICE.....means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

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.

COINSURANCE AMOUNT.....means the percentage amount paid by you for each Prescription filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

COMPOUND DRUGS.....means 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 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 Benefit Section. A current list is available on the Claim Administrator's website at www.bcbsil.com/rx-drugs/drug-lists/drug-lists. You may also contact a customer service representative at the telephone number shown on the back of your Identification Card for more information. Changes to this list will occur as frequently as quarterly.

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator 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 a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator 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 Prescription Drug Provider usually charges for Covered Services, or

(ii) the agreed upon cost between a Participating Pharmacy and a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator 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 and corresponding payment level, the Claim Administrator 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 "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 by accessing the Claim Administrator's website at *www.bcbsil.com*. You may also contact customer service for more information.

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.

NATIONAL DRUG CODE (NDC).....means a national classification system for the identification of drugs.

NON-PARTICIPATING PHARMACY OR NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER.....has the meaning set forth in the DEFINITIONS SECTION of this benefit booklet.

NON-PREFERRED BRAND NAME DRUG.....means a Brand Name Drug that is identified on the Drug List as a Non-Preferred Brand Name Drug. The Drug List is accessible by accessing the Claim Administrator's website at *www.bcbsil.com*.

PARTICIPATING PHARMACY OR PARTICIPATING PRESCRIPTION DRUG PROVIDER.....has the meaning set forth in the DEFINITIONS SECTION of this benefit booklet.

PHARMACY.....has the meaning set forth in the DEFINITIONS SECTION of this benefit booklet.

PREFERRED BRAND NAME DRUG.....means a Brand Name Drug which is identified on the Drug List as a Preferred Brand Name Drug. The Drug List is accessible by accessing the Claim Administrator's website at *www.bcbsil.com*.

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.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected but may also include drugs that are high-cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, refer to the Drug List by accessing the Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your Identification Card.

ABOUT YOUR BENEFITS

Drug List

Drugs listed on the Drug List are selected by the Claim Administrator 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 Claim Administrator. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the Drug List. Entire drugs classes are also regularly reviewed. 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.

Positive changes to the Drug List (e.g., adding drugs to the Drug List or 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 (i.e., drug exclusion, drug moving to a higher payment tier, or drugs requiring Prior Authorization) occur quarterly or annually. However, when there has been a pharmaceutical manufacturer recall or other safety concern, changes to the Drug List may occur more frequently.

The Drug List and any modifications are available by accessing the Claim Administrator's website at *www.bcbsil.com* or by calling the customer service toll-free telephone number on your Identification Card. You will be able to determine the Drug List that applies to your benefit plan 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.

Prior Authorization Requirement

Prior Authorization (PA): Your benefit program 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 Medically Necessary criteria is not met, coverage will be denied, and you will be responsible for the full charge incurred.

To find out more about Prior Authorization requirements or to determine which drugs or drug classes require Prior Authorization, you should refer to the Drug List by accessing the Claim Administrator's website at *www.bcbsil.com* 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.

You, 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 the dispensing limit 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, you, your prescribing Provider, or your authorized representative, can call the number on the back of your Identification Card to ask for a review. The Claim Administrator will let you, your prescribing Provider, or authorized representative, know the coverage decision within 15 calendar days after they receive your request. If the coverage request is denied, the Claim Administrator will let you, 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 and external exception review process you 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 by making the review as an urgent request. The Claim Administrator will let you, your prescribing Provider, or authorized representative know the coverage decision within 72 hours after they receive your request for an expedited review. If the coverage request is denied, the Claim Administrator will let you, 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 and external exception review 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. The Claim Administrator evaluates and updates dispensing limits quarterly.

If you require a prescription in excess of the dispensing limit established by the Claim Administrator, 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 Claim Administrator's website at www.bcbsil.com 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. 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. Some drugs covered under your plan may be subject to certain supply/fill limitations pursuant to diagnosis or new-to-therapy requirements, plan design, and/or state or federal regulations. For specific drug supply/fill information, please call the customer service toll-free telephone number located on your Identification Card. Specialty Drugs are limited to a 30-day supply. 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. For additional information about early refills, please see the **Prescription Refills** provision below.

Lost or Stolen Medication Overrides

Overrides for lost, stolen, and damaged prescription medication may be provided for up to one 30-day supply of prescription medication for each medication per year (365 days). Prescriptions will be subject to the Copayment Amount, Cost-Share Amount, and any Deductible shown in the Benefit Highlight section of this benefit booklet. If a Participant needs more than a 30-day supply of

prescription medication, they will be responsible to pay out of pocket until they are eligible for their next refill.

Vacation Override

Overrides needed for travel/vacation may be provided for up to one 90-day supply of prescription medication per year (365 days). When the prescription medication is a Specialty Drug or a controlled substance, overrides may only be granted for up to a 30-day supply. Prescriptions will be subject to the Copayment Amount, Cost-Share Amount, and any Deductible shown in the Benefit Highlights section of this benefit booklet. If a Participant needs more than the approved day supply, they will be responsible to pay out of pocket until they are eligible for their next refill.

Hormone Therapy to Treat Menopause

This plan provides benefits for Medically Necessary hormone therapy to treat menopause that has been induced by a hysterectomy.

Hormone Therapies to Treat Menopause

This plan provides benefits for Medically Necessary hormonal and non-hormonal treatments for menopausal symptoms, including all FDA approved administration modalities such as oral, transdermal, topical, and vaginal rings.

Blood Glucose Monitors for Treatment of Diabetes

This plan provides benefits for Medically Necessary blood glucose monitors (including continuous glucose monitors, non-invasive monitors and monitors for the blind) if a Physician has provided a written order. This coverage also includes related supplies, and training in the use of continuous glucose monitors.

Benefits for glucose monitors will be provided at no charge when obtained from a Participating Provider.

Abortifacients

Benefits will be provided at no charge for FDA approved abortifacients, including FDA-approved drugs prescribed for off-label use, 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 medication for the treatment of gender dysphoria, including FDA-approved drugs prescribed for off-label use, 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, including FDA-approved drugs prescribed for off-label use,

when obtained from a Participating Pharmacy, and for follow-up services, when obtained from a Participating Provider.

Multi Category Split-Fill Program

The first time using select medications in certain drug classes (e.g. medications for cancer, multiple sclerosis, lung disorders, etc.) or a medication that has not been filled within 120 days, you may only be eligible for a partial fill (14-15-day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. If you receive a partial fill, your Copayments and/or Coinsurance after your deductible will be adjusted to align with the quantity of medication dispensed. If the medication is working for you and your Physician wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit the https://www.bcbsil.com/rx-drugs/pharmacy/programs-other-members website.

Controlled Substances Limitations

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 to assess whether Medically Necessary or appropriate, and restrictions may include but not be limited to limiting coverage to services provided by a certain Provider and/or Pharmacy and/or quantities and/or days' supply for the prescribing and dispensing of the controlled substance medication. Additional Copayment Amounts and/or Coinsurance Amount and any deductible may apply.

Extended Prescription Drug Supply Program

Your coverage includes benefits for a 90-day supply of maintenance type drugs purchased from a Participating Prescription Drug Provider (which may only include retail pharmacies). Benefit payment amounts are described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

Benefits will not be provided for a supply of drugs or diabetic supplies purchased from a Prescription Drug Provider not participating in the extended retail prescription drug supply program.

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 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, Blue Cross and Blue Shield 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 describe below under the **BENEFIT PAYMENT FOR PRESCRIPTION DRUGS** provision in this Benefit Section.

COVERED SERVICES

Benefits for Medically Necessary Covered Drugs prescribed are available if the drug:

1. Has been approved by the FDA for the diagnosis and condition for which it was prescribed; or
2. Has been approved by the FDA for at least one indication; and
3. Is recognized by one of the following for the indication(s) of which the drug is prescribed to treat you for a chronic, disabling, or life-threatening illness:
   a. a prescription drug reference compendium, or
   b. substantially accepted peer-reviewed medical literature.

Some drugs are manufactured under multiple names and have many therapeutic equivalents. In such cases, the Claim Administrator 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.

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

Please Note: Prescription Drugs that are approved by the FDA through the accelerated approval program may be considered Experimental/Investigational and may not be covered.

Injectable Drugs

Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law, including, but not limited to, epinephrine injectors. Benefits will not be provided under this Benefit Section for any self-administered drugs dispensed by a Physician.

Immunosuppressant Drugs

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

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.

Diabetic Supplies 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

A separate Coinsurance Amount or Copayment Amount will be required for both insulin and insulin syringes regardless if they are obtained on the same day.

Self-Administered Cancer Medications

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

Compound Drugs

Benefits are available for Medically Necessary Compound Drugs. The drugs used must meet the following requirements:

(i) The drugs in the compounded product are FDA approved;

(ii) The approved product has an assigned National Drug Code (NDC); and

(iii) The primary active ingredient is a Covered Drug under this Benefit Section.

Compound Drugs will be provided at the Non-Preferred Brand Name Drug payment level.

Preferred Emergency Use Drugs

The following drugs categories will have Preferred Emergency Use medications available with zero ($0) cost share:

- Hypoglycemia
- Nitrates
- Opioid overdoses
- Severe allergic reactions

Vaginal Estrogen

This plan provides benefits for Covered vaginal estrogen products, or FDA-approved therapeutic equivalents, when determined to be Medically-Necessary.

SELECTING A PHARMACY

Participating Pharmacy

When you choose to go to a Participating Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription,
- provide the pharmacist with the birth date and relationship of the patient,
- pay the applicable deductible, if any, and
- pay the appropriate Copayment Amount for each Prescription filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

Participating Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Eligible Charge, or

- the amount for which you are responsible for as described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

You may be required to pay for limited or non-Covered Services. No Claim forms are required if you follow the above procedures.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access the Claim Administrator's website at *www.bcbsil.com* or call 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.

Non-Participating Pharmacy

If you choose to have a Prescription filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a Claim form to the Claim Administrator or to the prescription drug administrator with itemized receipts verifying that the Prescription was filled. The Claim Administrator will reimburse you for Covered Drugs equal to:

- the Copayment Amount indicated,
- less the amount for which you are responsible for as described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

Please refer to the provision entitled "Filing Outpatient Prescription Drug Claims" in the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet.

Home Delivery Prescription Drug Program

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

The Home Delivery 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 Home Delivery Prescription Drug Program.

Some drugs may not be available through the Home Delivery Prescription Drug Program. For a listing of Maintenance Drugs or if you have any questions about the Home Delivery Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the home delivery order form, you may access the Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your Identification Card. Mail the completed form, your prescription 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.

When you obtain Maintenance Drugs through the Home Delivery Prescription Drug Program, benefits will be provided according to the **Home Delivery Prescription Drug Program** payment provision described later in this Benefit Section.

For information about the Home Delivery Prescription Drug Program, contact your employer or group administrator.

90-Day Supply Program

The mail order program provides delivery of Covered Drugs directly to your home address. If you and your covered dependents elect to use the mail order service, refer to **Home Delivery Prescription Drug Program** provision below for applicable payment levels.

In order to receive benefits for Maintenance Drugs, you must obtain these medications through the mail order program or through one of the extended supply pharmacies. For a listing of Maintenance Drugs, you may access the website at *www.bcbsil.com* or contact customer service at the toll-free number on your Identification Card. Benefits are available for the original prescription plus one refill at a retail Pharmacy for Maintenance Drugs. For the third fill of the medication, benefits are only available for Maintenance Drugs through the mail order program or through one of the extended supply pharmacies. Benefits are not available if you continue to fill your prescription for Maintenance Drugs at a non-extended supply retail Pharmacy.

Some drugs may not be available through the mail order program. If you have questions about this mail order program, need assistance in determining the amount of your payment or need to obtain the mail order prescription form, you may access the website at *www.bcbsil.com* or contact customer service at the toll-free number on your Identification Card. Mail the completed form, your prescription(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 credit if the payment is too much; or (b) be billed for the appropriate if it is not enough.

YOUR COST

Out-of-Pocket Expense Limit

Expenses incurred by you for Covered Services under this Benefit Section will be applied towards out-of-pocket expense limit for your medical benefits. If, during one benefit period, your out-of-pocket expense limit is reached, benefits will be available for any additional eligible Claims for drugs or diabetic supplies during that benefit period will be paid at 100% of the Eligible Charge. Expenses incurred by you for Covered Drugs and diabetic supplies received from a Participating Pharmacy will be applied towards the Provider out-of-pocket expense limit as

indicated in the Benefit Highlights section of this benefit booklet. Expenses incurred by you for Covered Drugs and diabetic supplies received from a Non-Participating Pharmacy or non-preferred Specialty Pharmacy Provider will be applied towards the out-of-pocket expense limit as indicated in the Benefit Highlight section of this benefit booklet. Any additional expenses incurred by you received from a Non-Participating Pharmacy will not apply to your out-of-pocket expense limit.

BENEFIT PAYMENT FOR PRESCRIPTION DRUGS

How Member Payment is Determined

The amount that you are responsible for is based upon the drug tiers as described below and shown in the Benefit Highlights section.

- 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.

To receive additional information about your benefits for a drug, visit the Claim Administrator's website at *www.bcbsil.com* and log in to Blue Access for Members℠ (BAM) or call the number on the back of your Identification Card. Benefits will be provided as shown in the Benefit Highlights section and as described below.

Retail Pharmacy

The benefits you receive and the Copayment Amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

When you obtain Covered Drugs and diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment Amount of:

- **$10 for each prescription** - for Tier 1 Generic Drugs.
- **$40 for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **$60 for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs.

When you obtain diabetic supplies from a Participating Prescription Drug Provider, you must pay the Copayment Amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge.

When you obtain Covered Drugs or diabetic supplies from a Non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), 75% of the Eligible Charge will be paid minus the Copayment Amount.

One prescription means up to a 34 consecutive day supply of a drug. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain Maintenance Drugs, larger quantities may be obtained through the Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Pharmacy or call the customer service toll-free number on your Identification Card. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Home Delivery Prescription Drug Program

When you obtain drugs and diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment Amount of:

- **$20 for each prescription** - for Tier 1 Generic Drugs.
- **$80 for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **$120 for each prescription** - for Tier 3 Non-Preferred brand name drugs.

When you obtain diabetic supplies from a Participating Prescription Drug Provider, you must pay the Copayment Amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge.

One prescription means up to a 90 consecutive day supply of a drug. Certain drugs may be limited to less than a 90 consecutive day supply. For information on these drugs, contact your Participating Pharmacy or call the customer service toll-free number on your Identification Card. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

FlexAccess™

Your Employer has chosen to participate in FlexAccess™ (FlexAccess) which lowers your out-of-pocket costs for select drugs by obtaining drug manufacturer assistance when available. Under this program, out-of-pocket costs for select drugs may be set to the maximum amount of the current design or be based on any available manufacturer-funded assistance. Drug manufacturers may provide financial support for some, or all, of your out-of-pocket costs for select drugs. You may be required to pay an amount typically $0 - $35.00 for select drugs. Any amount paid through a drug manufacturer assistance program (e.g., manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons) will not apply to your Deductible (if part of the Plan) or yearly out-of-pocket maximum. The list of drugs covered under FlexAccess is subject to change. Please call the toll-free telephone number on the back of your Identification Card, or FlexAccess at 1-888-302-3618 to determine whether your drug is covered under this program. If you are taking a qualifying drug, a FlexAccess representative will contact you to participate in the program. You are not required to participate in this program; if you choose to opt out of the program, or if you do not affirmatively enroll in any manufacturer's assistance program, your cost for the select drug will be equal to the amount specified under your health care Plan benefits. Please note: If you are ineligible for the program — such as if a drug is excluded from a manufacturer's assistance program, if you switch to a drug

without available assistance, or if your drug is not on the FlexAccess drug list — your cost for the select drug will also be equal to the amount specified under your health care Plan benefits..

MedsYourWay™

MedsYourWay™ ("MedsYourWay") may lower your out-of-pocket costs for select Covered Drugs purchased at select in-network retail pharmacies. MedsYourWay is a program that automatically compares available drug discount card prices and prices under your benefit plan for select Covered Drugs and establishes your out-of-pocket cost to the lower price available. At the time you submit or pick up your Prescription, present your BCBSIL Identification Card to the pharmacist. This will identify you as a participant in MedsYourWay and allow you the lower price available for select Covered Drugs.

The amount you pay for your Prescription will be applied, if applicable, to your Deductible and out-of-pocket maximum. Available select Covered Drugs and drug discount card pricing through MedsYourWay may change occasionally. Certain restrictions may apply, and certain Covered Drugs or drug discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount for select Covered Drugs depending upon which retail pharmacy is utilized. For additional information regarding MedsYourWay, please contact a Customer Service Representative at the toll-free telephone number on the back of your Identification Card. Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting your Customer Service Representative at the toll-free telephone number on the back of your Identification Card.

EXCLUSIONS

For purposes of this Benefit Section only, the following exclusions shall apply:

1. Non-FDA approved drugs.
2. 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 regulatory guideline.
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 or durable medical equipment of any type (even though such devices may require a Prescription) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, 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. Covered Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to your cost determined under this Benefit Section.
12. Drugs which are repackaged by a company other than the original manufacturer.
13. 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.
14. 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.
15. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
16. 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.

17. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
18. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
19. 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.
20. 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.
21. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
22. Prescriptions for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, except for generic omeprazole/lansoprazole, unless otherwise determined by the Claim Administrator.
23. Athletic performance enhancement drugs.
24. Allergy serum and allergy testing materials.
25. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, the Claim Administrator 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 benefit section, the drug purchased will not be covered under any benefit level.
26. Drugs in a drug class where there is an over-the-counter alternative available, unless otherwise determined by the Group Health Plan.
27. Nonsedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant.
28. All Brand Name Drugs in a drug class where there is an over the counter alternative available.
29. Brand-name Proton Pump Inhibitors.
30. Infertility Drugs.
31. Medications in depot or long-acting formulations that are intended for use longer than the covered days' supply amount.
32. Devices and pharmaceutical aids.
33. Repackaged medications and institutional packs and drugs which are repackaged by anyone other than the original manufacturer.
34. Surgical supplies.
35. Ostomy products.

36. Diagnostic agents (except diabetic testing supplies or test strips).
37. General anesthetics.
38. Bulk powders.
39. New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.
40. Drugs determined to have inferior efficacy or significant safety issues.
41. Benefits will not be provided for any self-administered drugs under this Benefit Section dispensed by a Physician.
42. Male condoms.
43. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
44. Drugs without superior clinical efficacy which have lower cost therapeutics.
45. Vision enhancement products such as Vuity and Upneeq.
46. Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.
47. Services, supplies, drugs except GLP-1's + combos, except non GLP-1's and devices for the surgical treatment of any degree of obesity, whether provided for weight control or any medical condition.
48. Any drugs except GLP-1's + combos, except non GLP-1's provided for reduction of obesity or weight, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible covered persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled "Medicare Eligible covered persons" in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits ("EOMB") in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

EXCLUSIONS - WHAT IS NOT COVERED

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

— **Hospitalization, services and supplies which are not Medically Necessary.**
No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- — Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- — Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- — Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- — Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- — Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- — The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available 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 domestic or foreign corporation 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 for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment 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 or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 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 and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that were received prior to your Coverage Date or after the date that your coverage was terminated.

— Services or supplies from more than one Provider on the same day(s) to the extent benefits are duplicated.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s). You may contact Customer Service at the toll-free telephone number on the back of your Identification Card for more information about what Experimental/Investigational Services or Supplies may be excluded.

— Clinical technology, services, procedures, and service paradigms designated by a temporary (CPT® Category III) code are not covered, except for certain services otherwise specified by state or federal law, or federal coverage or billing guidelines.

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Care Program.

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this benefit booklet.

— Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This 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).

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

— 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.

— 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, battery implants, except as specifically mentioned in this benefit booklet.

— Services or supplies for intersegmental traction; all types of home traction devices and equipment; vertebral axial decompression sessions; surface EMGs; spinal manipulation under anesthesia; muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron; and balance testing through computerized dynamic posturography sensory organization test.

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

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this benefit booklet.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

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

— Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet rich plasma.

— Treatment of tissue damage or disease in any location with platelet-rich plasma.

— Immunizations, unless otherwise specified in this benefit booklet.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability, or mental disability.

— Hypnotism.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Health Care Plan.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or

similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

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

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

— Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

— Testing of blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels; urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover; cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby(premature ruptured membranes); and allergen specific IgG measurement.

— Acupuncture, whether for medical or anesthesia purposes, dry needling, or trigger-point acupuncture.

— Nutritional items such as infant formulas, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins, and herbal supplements, other than those specifically named in this benefit booklet.

— Reversals of sterilization.

— Naprapathic Services.

— Any related services to a non-covered service. Related services are a) services in preparation for the non-covered service; b) services in connection with providing the non-covered service; c) hospitalization required to perform the non-covered service; or d) services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

— Self-Administered drugs dispensed by a Physician.

— This Plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds, or its resin. Cannabis with THC as an active ingredient may be called marijuana.

— Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses, and group homes, except for Covered Services provided by appropriate Providers as defined in this benefit booklet.

— Services and appliances rendered or provided for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.

— Wigs (also referred to as a cranial prostheses)

Any of the following applied behavioral analysis (ABA) related services:

— Services with a primary diagnosis that is not Autism Spectrum Disorder;

— Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of "Qualified ABA Provider" in the DEFINITIONS SECTION of this benefit booklet;

— Activities primarily of an educational nature;

— Shadow or companion services; or

— Any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. COB does not apply to the Outpatient Prescription Drug Program Benefit Section.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this ''birthday'' type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
   - — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
   - — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

     Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the

Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person, or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You're receiving this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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 Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- 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 entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;

- ***In the event of retired employee health coverage:***
    - Commencement of a proceeding in bankruptcy with respect to the employer; or
    - The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For all other 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 Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered 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 of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

Contact your employer and/or the 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 during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

IF YOU HAVE QUESTIONS

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan 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 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 party to a Civil Union of an Eligible Person or as the dependent child of a party to a Civil Union. 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 a dependent who is party to a Civil Union or their child 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 Civil Union Partnership with the Eligible Person terminates. Your Civil Union Partnership 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.

HOW TO FILE A CLAIM AND APPEALS PROCEDURES

To obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your Identification Card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed, and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases, the Claim Administrator will send the payment directly to you or 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.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield of Illinois
   P. O. Box 660603

   Dallas, Texas 75266-0603

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits for Outpatient prescription drugs. This is primarily true when you did not receive an Identification Card, the Pharmacy will not transmit a Claim, or you

received benefits from a Non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a prescription drug Claim Form. These forms are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Prime Therapeutics
P.O. Box 25136
Lehigh Valley, PA 18002-5136

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received will not be eligible for payment.

Should you have any questions about filing Claims, please call the Claim Administrator.

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 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 Identification 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 is the contact information for the Illinois Department of Insurance consumer assistance and 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
Consumer_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, in response to a Claim, Pre-Service Claim or Urgent Care Clinical Claim, including any such determination, reduction, termination, or failure to provide 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 their 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.

- The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, with to file a complaint or wish to take up your matter with the IDOI, you may use either address below:

  IDOI Consumer Division
  320 W. Washington St.
  Springfield, Illinois 62767
  1-217-782-4515

  or

  IDOI Consumer Division
  115 S. LaSalle Street, 13th Floor
  Chicago, Illinois 60603
  1-312-814-2420
  web: *http://insurance.Illinois.gov*

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 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 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 30 calendar 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 30 calendar 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 have 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 their 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 may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the Complaint. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

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 act 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 notice of final external review decision 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 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.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS AND OTHER ENTITIES

The Claim Administrator hereby informs you that it has contracts with certain Providers (''Administrator Providers'') in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator's separate financial arrangements with Provider's work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for

purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After considering the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

The Claim Administrator or its subsidiaries or affiliates may also have ownership interests in or financial arrangements with certain Providers who provide Covered Services to covered persons and/or vendors or other third parties who provide services related to the Policy or provide services to certain Providers.

2. INTER-PLAN ARRANGEMENTS

I. Out-of-Area Services

Overview

The Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area the Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Claim Administrator's service area, you will receive it from one of two kinds of 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 Claim Administrator explains below how the Claim Administrator pays both kinds of Providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the Claim Administrator to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, the Claim Administrator will remain responsible for doing what we agreed in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

For Inpatient facility services received in a Hospital, the Host Blue's participating Provider is required to obtain Prior Authorization. If Prior Authorization 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.

When you receive Covered Services outside the Claim Administrator's service area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services, or
- The negotiated price that the Host Blue makes available to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your Identification Card to the provider to let them know that you are covered by the Claim Administrator.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the

service - the amount applied to your deductible, if any, and your coinsurance percentage - on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The Coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

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 modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Claim Administrator has used for your claim because they will not be applied after a Claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, the Claim Administrator may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to the Claim Administrator by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a non-participating Provider, that amount will be the difference between the Provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a Provider's billed charge, you will incur no liability, other than any related patient cost sharing under this agreement.

C. Special Cases: Value Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claim Administrator through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If the Claim Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your Employer on your behalf, the Claim Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Claim Administrator will include any such surcharge, tax, or other fee as part of the Claim Charge passed on to you.

E. Non-Participating Healthcare Providers Outside The Claim Administrator's Service Area

a. Member Liability Calculation

(1) In General

When Covered Services are provided outside of the Claim Administrator's service area by non-participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, the Claim Administrator may, but is not required to, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then the Claim Administrator may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area (and described in Section (a)(1) above); or

2. The following:

   a. For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or

   b. For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area 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 BlueCard service area, 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 BlueCard service area, 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, can 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. **You must contact the Claim Administrator to obtain Prior Authorization for non-emergency Inpatient services.**

- **Outpatient Services**

  Outpatient Services are available for Emergency Care, Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area 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 Blue Cross Blue Shield Global Core Claim**

  When you pay for Covered Services outside the BlueCard service area, 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 with 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 service center or online at www.bcbsglobalcore.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.

3. THE CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Claim Administrator's Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator hereby informs you that it 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 this Health Care Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of prescription drugs will vary. Some discounts are currently based on Average Wholesale Price ("AWP") which is determined by a third party and is subject to change. You understand that the Claim Administrator may receive such discounts. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

For the home delivery pharmacy and specialty pharmacy program partially owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the home delivery pharmacy and/or specialty pharmacy program. The Claim Administrator pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance

standards, including, but not limited to, Claims processing, customer service response, and home delivery processing.

"Weighted Paid Claim" refers to the methodology of counting Claims for purposes of determining the Claim Administrator's fee payment to Prime. Each retail (including Claims dispensed through PBM's Specialty Pharmacy program) paid Claim will be weighted according to the days' supply dispensed. A paid Claim is weighted in 34-day supply increments, so a 1-34 days' supply is considered 1 weighted Claim, a 35-68 days' supply is considered 2 weighted Claims, and the pattern continues up to 6 weighted Claims for 171 or more days' supply. The Claim Administrator pays Prime a Program Management Fee ("PMF") on a per weighted Claim basis.

The amounts received by Prime from the Claim Administrator, Pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a Claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Claim Administrator (as described above), administrative fees charge by Prime to Pharmacies and administrative fees charged by prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this benefit booklet. Additional information about these types of fees or the amount of these fees is available upon request. As of the effective date, the maximum that a PBM has disclosed to the Claim Administrator that the PBM will receive from any pharmaceutical manufacturer for manufacturer administrative fees is five and a half percent (5.5%) of the Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of the Claim Administrator and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to the PBM at the Claim Administrator's request; provided, however, that the Claim Administrator will advise the Employer if such maximum has changed.

Claim Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs 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 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. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially

owned by Prime Therapeutics, LLC. Neither the Employer nor you are entitled to receive any portion of such rebates.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufactures to cover the administrative costs of processing late payments). The Claim Administrator may also negotiate rebate contracts with pharmaceutical manufacturers. The Claim Administrator may receive such rebates from Prime or pharmaceutical manufacturers. You are not entitled to receive any portion of any such rebates.

4. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

c. A covered person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a covered person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

5. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is 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 Claim Administrator. Any contractual relationship between a Physician and an Administrator

Provider shall not be construed to mean that the Claim Administrator is providing professional service.

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

d. Each Provider provides Covered Services only to you and does not interact with or provide any services to your Employer (other than as an individual covered person) or your Employer's ERISA Health Benefit Program.

6. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (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 in care of your Employer 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. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

7. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

8. INFORMATION AND RECORDS

You agree that it is your responsibility to insure 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 benefits 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 indemnity 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 Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator 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 Claim Administrator may furnish similar information and records (or copies of records) to Providers, 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 the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

9. OVERPAYMENT

If your group's benefit plan or the Claim Administrator 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"), your group's benefit plan or the Claim Administrator 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 insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, 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 Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to a Contracted Provider; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy, if the future benefit payment owed is to a Contracted Provider; 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 Contracted Providers.

Further, the Claim Administrator has the right to reduce your benefit plan's payment to a Contracted Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same Contracted Provider and to remit the recovered amount to the other Blue Cross and Blue Shield plan or policy.

10. VALUE BASED DESIGN PROGRAMS

The Claim Administrator and your Employer has the right to offer medical management programs, quality improvement programs and health behavior wellness, incentive, maintenance, or improvement programs that allow for a reward, a contribution, a penalty, a differential in premiums or a differential in medical, prescription drug or equipment Copayments, Coinsurance or deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by the Claim Administrator or an entity chosen by the Claim Administrator to administer such programs. In addition, discount, or incentive programs for various health and wellness-related, insurance-related, or other items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Contact your Employer for additional information regarding any value-based programs offered by your Employer.

11. IDENTITY THEFT PROTECTION SERVICES

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 if you are no longer meet the definition of an Eligible Person. Services may change or be discontinued at any time with or without notice and the Claim Administrator does not guarantee 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 this benefit booklet.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or their insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents, or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

BENEFIT BOOKLET
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the benefit booklet to which this Amendment is attached and becomes a part of the benefit booklet. Unless otherwise required by Federal or Illinois law, in the event of a conflict between the terms on this Amendment and the terms of the benefit booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any Member, including Subscriber and Dependents.

The benefit booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the 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:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. 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 benefit booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the benefit booklet and this Amendment, those terms will apply only to their use in the benefit booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment 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 Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- 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
- Covered Services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:

    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of Illinois (BCBSIL) for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment 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 to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment 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 to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment 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 to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment 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.

2. Federal No Surprises Act Surprise Billing Protections

a. 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.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- 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).

- Air Ambulance Services received from a Non-Participating Provider if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. 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 expense limit, if any.

3. 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.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

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.

END OF BENEFIT BOOKLET

The information which follows is provided to you by Lincolnway Area Affiliation (Illinois School Insurance Network). The Claim Administrator is not responsible for its contents.

Family Security Benefit

In the event of the death of a covered employee, existing health coverage will remain in effect for the employee's surviving Dependents until the earliest of the following:

1. Date a surviving spouse remarries. Coverage for all Family members will also terminate at this time;
2. Date a Dependent qualifies for Medicare;
3. Date a Family member ceases to be an eligible Dependent under the Plan;
4. Last day of the 3-month period immediately following the death of the covered employee, except as otherwise specified in the following section;
5. Date of expiration of the last period for which timely payment of premium contributions have been made in the event surviving Dependents fail to make any required contribution for coverage. Premium contributions are determined by District policy;
6. Date the Plan is terminated.

Health coverage extended for Family members will not be affected by the death of the surviving spouse during the three (3) month (maximum) continuation of coverage.

Active Employee Survivor Continuation Coverage

The Plan will extend the opportunity to continue coverage to Eligible Survivors of certain Eligible Active Employees who would otherwise lose coverage due to the death of the employee. Coverage will be subject to all terms and provisions of the Lincolnway Area Affiliation (Illinois School Insurance Network) Employee Benefit Plan and will also be subject to the following:

1. An "Eligible Active Employee" means any employee covered by the Plan who has a minimum of five (5) years of continuous service with a participating District(s) under the Plan.
2. "Eligible Survivors" means the legal spouse and any eligible Dependents of the deceased Eligible Active Employee, provided that Dependent coverage was maintained and in effect immediately prior to the date of death.
3. Eligible Survivors may continue coverage under the Plan at their own expense; normal provisions of the Plan will apply. Eligible Survivors must contact the District Office and apply to continue within ninety

(90) days of the date of the death of the Eligible Active Employee. If there is a surviving spouse, the spouse must be enrolled in order to provide benefits to any eligible Dependent(s).

4. Premiums are due in advance and billed by the District Office. Premiums, as established periodically by the Plan, are subject to change. Any change in premiums will be communicated to Eligible Survivors.

Termination of Active Employee Survivor Continuation Coverage

Coverage will automatically terminate at 12:00 midnight upon the earliest of the following dates:

1. For the surviving spouse:
    a. Date of expiration of the last period for which timely payment of premium contributions have been made;
    b. Date the surviving spouse remarries;
    c. Date the surviving spouse becomes covered by another group plan;
    d. Date the surviving spouse attains age 65;
    e. Date of the surviving spouse's death;
    f. Date a surviving spouse files a written election to discontinue coverage;
    g. Date the Plan is terminated or the date Surviving Spouse coverage is terminated from the Plan.
2. For eligible Dependents:
    a. Any of the above events;
    b. Date a surviving Dependent is eligible to become covered by another group Plan;
    c. Date a surviving Dependent ceases to be an eligible Dependent under the Plan.

All other terms and provisions of the Plan apply.

Benefits Following Retirement

A covered employee who meets the following qualifications will be considered a "Retiree" eligible to elect to retain Plan coverage upon retirement:

1. The employee retires between age 50 and age 55 and is eligible for and receiving pension benefits from the Illinois Teachers Retirement system; or,
2. The employee retires between age 55 and age 65 and has 5 or more years of service with a participating district.

An eligible Retiree may elect to remain covered under the Plan, provided he or she pays the applicable premium and applies for the coverage extension within thirty (30) days from his or her last day of work.

If Retiree coverage is elected, benefits will be provided according to the terms and conditions that apply to active employees under this Plan.

A covered employee who retires after age 65 or a covered Retiree who has reached age 65 may elect coverage under the Medicare Supplement Plan, provided he or she pays the applicable premium. The covered employee must apply for coverage within 30 days from the date of retirement; a covered Retiree must enroll within 30 day of the date he or she attains age 65. Information regarding the coverage available through the Medicare Supplement Plan can be obtained from your District Office.

Retiree Survivor Continuation Coverage

The Plan will extend the opportunity to continue coverage to a Surviving Spouse (and any eligible Dependents) of a covered Retiree who would otherwise lose coverage due to the death of the Retiree. Coverage is subject to all terms and provisions of the Lincolnway Area Affiliation (Illinois School Insurance Network) Employee Benefit Plan and is also subject to the following:

1. "Surviving Spouse" as used herein refers to the Retiree's legal spouse and eligible Dependents whose coverage was in force immediately prior to the death of the Retiree.
2. The Surviving Spouse (and any eligible Dependents) of a deceased Retiree will be considered eligible, provided the Retiree was enrolled for Dependent coverage immediately prior to the date of death.
3. The Surviving Spouse may continue coverage, at his or her own expense, under the Retiree provisions of the Plan. The eligible Surviving Spouse must contact the District Office and apply to continue coverage

within ninety (90) days of the date of the death of the eligible Retiree. If the Surviving Spouse is under age 65, he or she must also notify the District Office within thirty (30) days of his or her 65th birthday in order to continue coverage under the Medicare Supplement plan.

The Surviving Spouse must be enrolled in order to provide benefits to any eligible Dependent children.

4. Premiums, as established periodically by the Plan, are due in advance and billed by the District Office. Premiums are subject to change. Any change in premiums will be communicated to Covered Persons.

Effect of COBRA Continuation Coverage

In the event of the death of a Retiree, the eligible Surviving Spouse will have the opportunity to elect Retiree Survivor Continuation Coverage or any COBRA continuation coverage that may be applicable.

If a Surviving Spouse and/or any Dependents elect to continue coverage under COBRA continuation, the right to Retiree Surviving Spouse Continuation Coverage is forfeited.

If a Surviving Spouse elects Retiree Survivor Continuation Coverage and such coverage ceases for reasons stated below, the Surviving Spouse (and Dependents) will not be eligible for COBRA continuation coverage.

Termination of Retiree Survivor Continuation Coverage

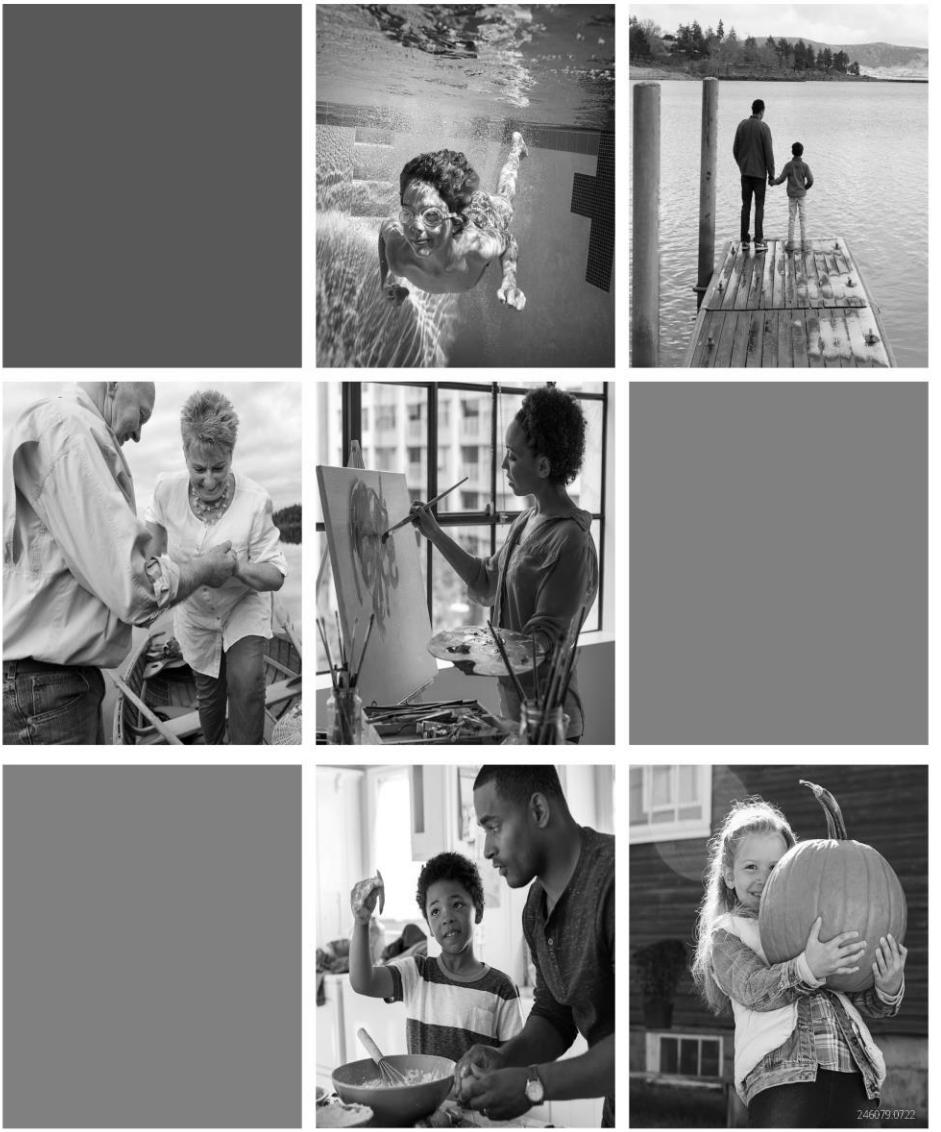
Coverage will automatically terminate at 12:00 midnight upon the earliest of the following dates:

1. For the Surviving Spouse:
    a. Date of expiration of the last period for which timely payment of premium contributions have been made;
    b. Date a Surviving Spouse remarries;
    c. Date of the Surviving Spouse's death;
    d. Date a Surviving Spouse files a written election to discontinue coverage;
    e. Date the Plan is terminated or the date Surviving Spouse coverage is terminated from the Plan.
2. For Eligible Dependents:
    a. Any of the above events;
    b. Date a Family member ceases to be an eligible Dependent under the Plan.

All other terms and provisions of the Plan apply.

Unclaimed Payments

Any benefit payment issued under the Plan that is not cashed by the payee within the twelve-month period immediately following its date of issue will be considered void and will only become a Plan liability upon receipt of the employee's written request for re-issuance. Such request must be made within the twenty-four (24) month period immediately following the date the benefit payment was issued. Any request that is filed later will be denied.



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ASO-1

Effective Date: January 1, 2026

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.