

Summary Plan Description
Health Savings Plan for CVS Health

Administered by

Blue Cross and Blue Shield of Illinois

Effective June 1, 2016

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INTRODUCTION

The Health Savings Plan (HSP) for CVS Health (“CVS”) is an important employee benefit designed to help keep good health care affordable for you and your family. It provides benefits for preventive care and access to special programs that focus on helping you stay healthy, plus the coverage you need when faced with an illness or injury.

The HSP (the “plan”) is a component plan under the CVS Health Welfare Benefit Plan (the “Plan”) which is maintained by the Plan Sponsor, CVS Pharmacy, Inc. and its related entities and divisions that participate in the Plan (collectively, “CVS”) for the exclusive benefit of, and to provide welfare benefits to, its eligible employees, their spouses, and eligible dependents.

ABOUT THIS BOOKLET

This booklet is designed to provide a clear and understandable Summary of the HSP and serves as the Summary Plan Description (SPD) required for plans subject to ERISA such as the CVS HSP. The SPD can help you understand the main features of the plan, such as who is eligible, what is covered and not covered, how to file a claim and what happens when you are no longer eligible for coverage, as well as information about certain rights and responsibilities you have as a person covered under this plan. It also provides information on special programs available to help you on your path to better health. It’s your reference for benefit details, and can help you use the HSP effectively.

To find a topic, check the TABLE OF CONTENTS. To understand what certain words mean, turn to the DEFINITIONS section. A summary of your benefits is provided in the BENEFIT HIGHLIGHTS section.

How to Use This SPD

- Read the entire SPD to understand how the HSP works, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- Capitalized words in the SPD have special meanings and are defined in the DEFINITIONS section.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

If you have questions about your medical benefit, call the number on the back of your ID card or **myHR** at 1-888-MY-HR-CVS (1-888-694-7287).

IMPORTANT NOTICES

The HSP described in this SPD is administered by Blue Cross and Blue Shield of Illinois. The benefits are effective only while you are covered under the plan.

This SPD is designed to meet your information needs and the disclosure requirement of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this plan. Because the HSP is a component plan under the CVS Health Welfare Benefit Plan (“the Plan”), the benefits described in this SPD are also governed by the terms of the separate governing plan documents, including the CVS Health Welfare Benefit Plan document. If there is a conflict between this SPD and the legal plan documents controlled the operation of the Plan, the legal document will govern.

Although CVS currently intends to continue the benefits provided by the plan, CVS reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add benefits or terminate this plan or this SPD, in whole, or in part and in its sole discretion, without prior notice to or approval by plan participants and their beneficiaries. Any change or amendment to or termination of the plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in case of termination), whether prospective or retroactive, to the plan. The amendment is effective only when approved by the body or person to who such authority is formally granted by the terms of the plan. No person or entity has any authority to make oral changes or amendments to the plan.

Non-discrimination

The plan may not discriminate against any individual or his/her dependent with respect to health coverage on the basis of a health factor. The plan shall not:

- Adjust premium contribution amounts based on genetic information;

- Request or require an individual or his/her family member to undergo a genetic test (except in certain circumstances related to research); or
- Request, require or purchase genetic information with respect to any individual prior to his/her enrollment in the plan or coverage in connection with enrollment.

DISCLAIMER

CVS Human Resources (HR) and Blue Cross and Blue Shield of Illinois employees often respond to outside inquiries regarding coverage as part of their job responsibilities. These employees do not have the authority to extend or modify the benefits provided under the HSP.

In the event of a discrepancy between information given by either a CVS HR or Blue Cross and Blue Shield of Illinois employee and the written terms of the plan, the terms of the plan will control.

Any changes or modifications to benefits under the plan must be provided in writing and made according to the plan's amendment procedures.

Administrative errors will not invalidate benefits otherwise in force or give rise to rights or benefits not otherwise provided by the plan.

ELIGIBILITY AND ENROLLMENT

YOUR ELIGIBILITY

You are eligible for medical coverage under the HSP if you are considered an eligible employee, as described below, and you are working in the United States.

Eligibility Date

The date on which you are first eligible for coverage is your “Eligibility Date”.

In compliance with the Patient Protection and Affordable Care Act (PPACA), CVS measures hours of service for benefits eligibility for employees who are not hired into exempt positions.

Hour of Service

Generally, an “hour of service” is an hour actually worked, an hour for which you are paid (such as vacation, PTO or time on leave), or an hour during which you are on an approved unpaid leave of absence. CVS will evaluate your hours to determine whether you qualify for medical coverage under the Measurement Period rules, described below.

Special rules apply if you have a break in service, take a leave of absence, or change your job classification. For questions regarding eligibility, contact **myHR** at **1-888-MY-HR-CVS (1-888-694-7287)**.

New Hires

If you are a new hire, you are considered an eligible employee as of your date of hire if you are hired into an exempt position or other position in which you are expected to work at least 30 hours per week. Your Eligibility Date is the 91st day of continuous employment with CVS. If you are in a non-exempt position, your continued eligibility will depend on whether you meet the requirements for current employees as described below.

If you are a new hire who is not hired into a position in which you are expected to work at least 30 hours per week, you are not considered an eligible employee. However, you may become an eligible employee if you average 30 or more “Hour of Service” (described above under “Your Eligibility”) per week during your initial Measurement Period, as defined below.

If you are a new hire who is not hired into an exempt position, your hours of service will be measured for future benefits eligibility, as follows:

- Beginning with your date of hire, your average hours worked in the first 11 months of your employment, which is your initial Measurement Period, will be measured.
- An administrative period of less than 90 days will follow the initial Measurement Period, during which you will be notified if you have

become eligible for coverage during your initial Stability Period, as defined below. If you have become eligible, you will also be notified of your eligibility date and how to elect coverage, if applicable.

- Your Eligibility Date will generally be the 1st of the second calendar month following the end of the initial Measurement Period. In some cases, depending on your date of hire, your Eligibility Date could be the 1st of the first calendar month following the end of your initial Measurement Period.
- If you average 30 or more hours of service during your initial Measurement Period, you will be eligible for and offered medical benefits under the plan beginning with your Eligibility Date for a 12 month period, which is called your initial Stability Period.
- After the end of your initial Stability Period, you will remain covered through the end of the then-current Plan Year, only if you averaged 30 hours or more during the most recent completed annual ongoing Measurement Period (March 3 of preceding year through March 2 of current year, as discussed further below under the “Current Employees” section)
- You will be continuously measured as a current employee going forward, as outlined below, for medical benefits eligibility.

Current Employees

If you are in an exempt position, you are eligible to elect medical coverage under the HSP during the Annual Enrollment Period. If you are enrolled in medical coverage under the plan and move to a non-exempt position in which you are working less than 30 hours per week you will remain covered under the plan for the remainder of the Plan Year.

If you are a current employee who is not in an exempt position, you are considered an eligible employee for a Stability Period under the plan (described below) if, during the related Measurement Period under the plan (described below), you are an employee of CVS and you average 30 or more hours of service per week.

Stability Period and Measurement Period

For this purpose:

- A Stability Period is a 12 month period beginning on June 1 and ending on May 31 and coincides with the Plan Year. In determining whether you are an eligible employee for a Stability Period, the Plan Administrator will review your average hours of service during the Measurement Period that immediately precedes the Stability Period.

- The Measurement Period is a 12 month period beginning on March 3 of the preceding year and ending on March 2 of the current year.

If you average 30 or more hours of service per week during a Measurement Period, you will be considered an eligible employee for the upcoming Plan Year (June 1 through May 31).

You will be notified of your eligibility date and how to elect coverage for the upcoming Plan Year.

Continued eligibility for medical benefits is reviewed at the end of each Measurement Period for all current employees not in exempt positions.

Rehires

If you terminate employment with the Company and are rehired by the Company, you will be treated as a new hire only if the period between the termination and rehire exceeds 13 consecutive weeks.

Additional Eligibility Requirements

In order to be considered an eligible employee, you must also satisfy the following additional eligibility requirements (“Additional Eligibility Requirements”):

- You are not covered by a collective bargaining agreement where benefits were the subject of good faith bargaining (unless that agreement provides for participation in the plan).
- You are not classified, by CVS in its sole discretion under its customary worker classification procedures, as a leased employee, independent contractor, consultant or other designation that would exclude eligibility (whether or not you actually are an employee and regardless of whether you are later reclassified as an employee by a governmental agency for the period at issue), unless your specific contract or agreement with CVS provides for coverage under the plan.
- You have been determined by the Plan Administrator to live in the Service Area covered under the respective plan.

DEPENDENT ELIGIBILITY

You may enroll your eligible dependents (described below) when you are first eligible for plan coverage and during the plan’s Annual Enrollment period. Generally, you may also enroll newly eligible dependents within 30 days of their becoming eligible by marriage and within 60 days of their becoming eligible by birth, adoption, or placement for adoption. You may only drop coverage of an eligible dependent upon a Change in Status event (described below) or during the

plan's Annual Enrollment period, unless your dependent's coverage is paid for on an after-tax basis (in which case you can disenroll that dependent at any time).

No person can be covered as both an employee and a dependent. In addition, no dependent may be covered without the employee having coverage. No person can be covered as a dependent of more than one employee under the plan.

You should be aware that not all coverage for eligible dependents under the plan can be paid for on a pre-tax basis. As discussed under the "Paying for Coverage" section below, due to current tax laws coverage for dependents can be paid for on a pre-tax basis only if the dependent:

- is your legal spouse, your biological child, adopted child, step-child, child for whom you are the legal guardian, or a child who is the subject of a "qualified medical child support order" ("QMCSO") or
- meets the IRS' definition of a tax dependent under Section 152 of the Internal Revenue Code.

Shortly after you enroll a dependent, CVS' audit partner, Dependent Verification Services, will send you a letter requesting proof that your dependent is eligible under the terms of the plan. Required documentation may include a government-issued marriage certificate, government-issued birth certificate, and a Federal tax return.

Note that a child who is not your biological child, legally adopted child, or child for whom you are the legal guardian is not your eligible dependent if you divorce or legally separate from, or otherwise terminate the relationship with your legal spouse.

Note: If a covered person is determined to be ineligible or unverified, he or she will be dropped from coverage under the plan, and you will be required to pay to the plan all claims incurred on behalf of ineligible or unverified person(s). If this is the case, you may not be eligible for future coverage under the plan until you pay all amounts owed. If the termination of coverage for such a person results in a coverage level change, such as from family to individual coverage, you will not be refunded any premiums deducted from your pay at the higher coverage level. Your coverage level will be adjusted only for pay periods that occur after the removal of any unverified

Eligible Spouse

Your legal spouse* of the same or opposite sex. To confirm eligibility for coverage under the plan, CVS requires a copy of your marriage certificate and proof that you remain married.

**If you are legally separated from your spouse, your spouse is not an eligible dependent.*

Eligible Children

The following is a list of dependent children who are eligible for medical benefits under the plan.

- A child who is less than age 26, where the child is one of the following:
 - Your biological child, legally adopted child (including a child placed with you for adoption), step-child* from a legal spouse, or child for whom you are the legal guardian (as determined by an authorized placement agency, or by judgment, decree, or any order of a court).

**A child who is your step-child will no longer be an eligible dependent in the event of a divorce or legal separation.*
 - Your legal spouse's or legally adopted child, or a child for whom your legal spouse is the legal guardian (as determined by an authorized placement agency, or by judgment decree, or any order of a court).
 - Your or your legal spouse's unmarried grandchild, provided he or she:
 - is also your tax dependent,
 - resides with you for more than one-half of the year (or, if less than one-half of the year has resided with you since birth or adoption), and
 - receives over 50% of his or her support and maintenance from you or your spouse.

Shortly after you enroll a dependent, you will be required to attest to the Plan Administrator (and provide supporting documentation) that a child meets the above requirements. In addition, you may be asked to re-certify annually that a grandchild continues to meet the plan's requirements.

- A child who is 26 or older and has a physical or mental disability that is expected to last for a continuous period of not less than 12 months (as

determined by the Insurance Company or Claims Administrator, as applicable), provided the child:

- is incapable of engaging in substantial gainful activity;
- receives over 50% of his or her support and maintenance from you or your legal spouse; and
- has the same residence as you for more than one-half of the year (or if less than one-half of the year, has resided with you since birth or adoption).

You must provide proof of the ongoing disability as often as requested by the plan. The child must be disabled prior to age 26 or become disabled while covered as a dependent under the plan for purposes of medical benefits.

A child who is the subject of a “qualified medical child support order” (“QMCSO”) as determined by a judgment, decree, or any order of a court. Note that the Plan Administrator will not recognize an order that requires a child of your legal spouse (other than your step-child) to be covered under the plan if your spouse does not live with you.

Shortly after you enroll a dependent you will be required to attest to the Plan Administrator (and provide supporting documentation) that a child meets the above requirements. In addition, you may be asked to recertify annually that a grandchild continues to meet the plan’s requirements.

HOW TO ENROLL AND WHEN YOUR COVERAGE BEGINS

General Enrollment

You will be notified of your Eligibility Date and how to elect coverage. You are then required to take action before your Eligibility Date. You can enroll from home or work anytime (24/7) by logging onto: **myhr.cvs.com**. Once at the myhr.cvs.com site, you will need to follow the prompts on screen to make your coverage elections. When you enroll at myhr.cvs.com, your Eligibility Date will be reflected. Also, additional instructions are supplied with your enrollment materials. Customer Service Representatives are available to answer your enrollment questions. Call **myHR** at **1-888-MY-HR-CVS (1-888-694-7287)**, 24 hours a day, 7 days a week.

You must enroll prior to your Eligibility Date, otherwise you will have waived coverage. If you waive coverage, you will need to wait to enroll, assuming you are eligible, until the next Annual Enrollment period that begins in April or until your next enrollment opportunity. You may be able to enroll mid-year if you experience a Change in Status or a Special Enrollment event (described below). Your enrolled dependents’ coverage takes effect on the same date your coverage takes effect.

Rehires.

If you are a rehired employee who returns to an employment position in which you are expected to work at least 30 hours per week within 13 weeks of your date of termination, you remain eligible based on your prior period of employment, but you still must make new benefit elections. The benefit elections you had in place on your last day of employment will not automatically resume on the date you are rehired, and you will have to re-enroll in benefits.

By enrolling in the plan, you authorize CVS to deduct coverage contributions from your pay. In the event you owe premium contributions to the plan, you are also authorizing CVS to deduct the outstanding benefit contribution balance through payroll deductions in an amount not to exceed double the required contribution of the benefit option and level you selected, until the balance is repaid in full. Any questions about enrolling should be directed to *myHR* at **1-888-MY-HR-CVS (1-888-694-7287)**.

Annual Enrollment

The Annual Enrollment period is the annual period of time during which you are given the opportunity, assuming you are eligible, to enroll in the plan, drop coverage, or change your coverage level (for example, from employee to employee plus one or more children). The Annual Enrollment period commences in April, and elections made during this period are effective June 1. You may need to reenroll in the plan during each Annual Enrollment period to continue your previous year's coverage. Look for information from CVS regarding Annual Enrollment to determine whether reenrollment action is required to continue coverage into the next Plan Year.

Special Enrollment

Ordinarily, if you do not enroll for medical coverage when you are first eligible, you must wait until the next Annual Enrollment period. However, in certain cases if you are eligible during a Plan Year or portion of the Plan Year, you and/or your dependents may be eligible for "Special Enrollment" outside of the Annual Enrollment period. If this is the case, you may make election changes concerning your medical benefits under the plan. You may also change benefit options when a Special Enrollment event is the result of marriage, birth, or adoption.

If you or your dependent experience a Special Enrollment event described below under Special Enrollment Rules, you must take action within the time period described below to make your election change. You can do this by logging onto myhr.cvs.com, or calling *myHR* at **1-888-MY-HR-CVS (1-888-694-7287)** during normal business hours – to advise CVS of the Special Enrollment event and make your election change. Once at myhr.cvs.com, look for the "Life Events" menu, which will provide you with directions on how to make your election change online. If you do not see the Life Event that pertains to you at myhr.cvs.com, be sure to call *myHR* within the required time period to make your

election change. Note that for Special Enrollment events relating to Medicaid or CHIP eligibility, you must call **myHR** within the required time frame to make your election change (online election changes due to these events are not available).

Note: Coverage is retroactive to the date of the event or loss of coverage, provided you complete the enrollment transaction by the required deadline. By completing the enrollment transaction, you authorize CVS to deduct contributions required for retroactive coverage from your pay.

Special Enrollment Rules

If you are in a position in which you are expected to work at least 30 hours per week, you have special enrollment rights (described below). If you are not in a position in which you are expected to work at least 30 hours per week, but were considered eligible for medical coverage due to your hours of service during a Measurement Period, you will have special enrollment rights described below during the Stability Period that applies to you.

Loss of Other Coverage

If you decline enrollment in medical benefits under the HSP for yourself and your dependents due to your other health coverage, you may be able to enroll yourself and your dependents for these benefits under the plan within 30 days after the other coverage ends. Go to **myHR** at **myhr.cvs.com**.

For this Special Enrollment event to apply, you must have stated that you were declining coverage under the plan for you and/or your dependents due to other health coverage, and you or your dependent's other coverage must be lost because it was one of the following:

- COBRA coverage that was exhausted;
- Other coverage for which you or your dependent are no longer eligible (for example, by reason of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or incurring a claim that would meet or exceed a lifetime limit on all benefits under the other coverage); or
- The coverage was provided by another employer that ceased to pay for it.

If you fail to provide the written statement required above (stating that you were declining coverage due to coverage under another plan), the plan may not provide Special Enrollment to you or any of your dependents.

Note: Neither a loss of coverage due to a failure to pay premiums nor a loss of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation) will trigger Special Enrollment rights.

Addition of New Dependent

If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent for medical/prescription coverage under the plan, provided you enroll your new dependent within 30 days after your date of marriage and within 60 days after a birth, adoption, or placement for adoption. To enroll, go to **myHR** at **myhr.cvs.com**. Changes to your coverage are effective as of the date of the event.

Medicaid and CHIP

If you or a dependent are eligible for coverage under the terms of the plan, but you are not enrolled, you or your dependent may enroll for medical/prescription coverage under the terms of the plan if either one of the following conditions is met:

- You or your dependent are covered under a Medicaid plan or a State child health plan under the Children's Health Insurance Program ("CHIP"), and coverage under the Medicaid or CHIP plan is terminated because of a loss of eligibility for such coverage. You may then request coverage under the HSP no later than 60 days after termination of the Medicaid or CHIP coverage; or
- You or your dependent become eligible for a premium assistance program (that could be used toward the plan costs) under a Medicaid or state child health plan under CHIP (including any waiver or demonstration project conducted under or in relation to such a plan). You may then request coverage under the HSP no later than 60 days after the date you or your dependent are determined to be eligible for the premium assistance.

Call **myHR** at **1-888-MY-HR-CVS (1-888-694-7287)** during normal business hours within 60 days after termination of the Medicaid or CHIP coverage or the date you or your dependents are determined to be eligible for premium assistance, as applicable. The call center representative will make your election changes on the phone at the time of your request.

LEVEL OF COVERAGE

With regards to medical coverage, you may choose from four levels of coverage: coverage for you only, coverage for you plus your legal spouse, coverage for you plus one or more children, or family coverage (you, your legal spouse, and children).

PAYING FOR COVERAGE

Generally, you and CVS share the cost of your plan coverage (with CVS paying the majority of the cost).

Your contributions for plan coverage are not used to pay plan expenses for vendors or other service providers who are affiliated with CVS (such as CVS Caremark), except as may be permitted by ERISA.

Your contributions will be deducted from your pay on a before-tax basis and are subject to change on June 1 of each year or when you change your benefits. Paying for your coverage on a before-tax basis means you don't pay Social Security or Federal (and, in most cases, state) income tax on your contributions. Since your taxable earnings are lower, you pay less in taxes. Also, CVS's contributions towards your medical and prescription coverage are not taxed. This before-tax-treatment is available for coverage for your legal spouse (whether same or opposite sex) and for a dependent child who is your biological child, adopted child (or child placed with you for adoption), step-child, or a child for whom you are the legal guardian. However, before-tax treatment is not available for coverage of other dependents unless the dependent is considered your dependent for federal tax purposes.

If you fail to pay monies owed to the plan, the Plan Administrator may pursue any means of collection, including reporting the debt to a credit agency or prohibiting you from enrolling in the plan in the next Annual Enrollment period.

CHANGING YOUR COVERAGE

You may change your coverage under the plan during the Annual Enrollment period each year or during the year if you have a Change in Status as provided below. Changes to your coverage during the year due to a Change in Status are effective as of the date of the Change in Status.

If you want to change your coverage due to a Change in Status, you must go to *myHR* at **myhr.cvs.com** to make the change within 30 days of the date of your Change in Status. However, for birth or adoption, you have up to 60 days to make the change. You will be able to report your Change in Status and change your coverage at the same time. If you do not complete the transaction within the required timeframe, you will have to wait until the next Annual Enrollment period to add coverage under the plan.

A change in coverage must be consistent with your Change in Status. For example, if you become divorced, you may drop coverage for your former spouse, but you cannot change your own coverage options. Changes in Status include:

- Marriage, divorce, legal separation or annulment;
- Birth or adoption (or placement for adoption) of your child, or the addition of your step-children;

- Death of a dependent;
- Change in employment status including termination or commencement of employment, a commencement of or return from an unpaid leave of absence or change in work schedule (including a change from a position in which you are expected to work less than 30 hours per week to a position in which you are expected to work at least 30 hours per week or vice versa) for you or your dependent that affects eligibility for this plan or another employer plan;
- Change in health insurance eligibility due to a relocation of residence or work place for you;
- A judgment, decree, or order resulting from your marriage, divorce, legal separation, annulment, or change in child custody requiring you to add or allowing you to drop coverage for your dependent child (this is dependent on state mandates);
- Your or your spouse's or dependent child's entitlement, or loss of entitlement, to Medicare or Medicaid benefits;
- A significant increase in cost of coverage, or a reduction in benefits, under the plan or your spouse's plan;
- A change in a dependent's coverage under another employer plan that is permitted under that plan and applicable IRS regulations; and
- If your spouse gains coverage for you during his/her plan's annual enrollment, you may drop coverage or if your coverage under another employer plan is dropped at the other plan's annual enrollment, you may add coverage, provided the period of coverage for that other plan is different than the period of coverage for this plan. You must show documentation from your spouse's plan of such activity.

You may drop coverage for you and your applicable dependents if:

- You experience a change in your employment status from a position in which you were expected to work 30 hours or more per week to a position where you are not expected to work 30 hours or more per week, even if you remain eligible for medical and prescription plan coverage, provided you represent that you and any covered dependents have enrolled or intend to enroll in another plan that provides minimum essential coverage (such as Marketplace coverage or coverage through another employer medical plan) for new coverage that is effective no later than the first day of the second month following the month that includes the date coverage is revoked; or
- You become eligible to enroll in a qualified health insurance plan offered through the Marketplace during a special enrollment period or annual open enrollment period for the Marketplace, provided you represent that

you have enrolled or intend to enroll yourself and your applicable dependents in such a qualified health insurance plan through the Marketplace and your new coverage is effective beginning no later than the day immediately following the last day you and your applicable dependents have coverage under the plan.

You are not allowed to drop your coverage other than during the Annual Enrollment period unless you have a Change in Status.

For more information, go to **myHR** at myhr.cvs.com or call **myHR** at **1-888-MY-HR-CVS (1-888-694-7287)**. If you believe you are eligible to make a mid-year election change due to a Change in Status described above, go to **myHR** at myhr.cvs.com and make your enrollment change within 30 days of the date of the event (except in the case of a birth or adoption, in which case you have 60 days to make your enrollment change).

COVERAGE FOR MEMBERS WHO ARE HOSPITALIZED ON THEIR EFFECTIVE DATE

If you are in the hospital on your effective date of coverage, health care services related to such hospitalization are covered provided that the health care services are received in accordance with the terms, conditions, exclusions and limitation of the plan. Please notify the Claims Administrator of your hospitalization within forty-eight (48) hours of the effective date, or as soon as is reasonably possible. As always, benefits paid in such situations are subject the Coordination Benefits provision outlined in this Summary.

HOW THE PLAN WORKS

This section describes how the HSP works and how to make the most of your coverage when you need care. You'll find information about sharing the cost of your care, choosing a provider, certain important plan rules and requirements, and how a Health Savings Account works with the HSP to pay for eligible health care expenses—now or anytime in the future.

OVERVIEW OF THE HEALTH SAVINGS PLAN (HSP)

The HSP is a qualified high-deductible health plan that can be linked with a Health Savings Account (HSA) to help you pay for your eligible medical expenses (includes prescription drug expenses). Under the HSP, you share in the cost of your medical care by paying the deductible and **coinsurance**, as shown and explained further below.

Here's an overview of your coverage under the three HSP options:

Feature	Plan	Participating Provider	Non-Participating Provider
Deductible <i>Combined deductible applies to medical expenses and prescription drug expenses through CVS Caremark prescription drug program.</i>	HSP Option 1	Individual Coverage: \$1,500 Family Coverage: \$3,000	Individual Coverage: \$3,000 Family Coverage: \$6,000
	HSP Option 2	Individual Coverage: \$2,000 Family Coverage: \$4,000	Individual Coverage: \$4,000 Family Coverage: \$8,000
	HSP Option 3	Individual Coverage: \$3,000 Family Coverage: \$6,000	Individual Coverage: \$6,000 Family Coverage: \$12,000
Coinsurance	All HSP Options	Plan pays 80% after the deductible is met You pay 20% after the deductible until out-of-pocket maximum is met	Plan pays 50% after the deductible is met You pay 50% after the deductible until out-of-pocket maximum is met
Out-of-Pocket Maximum* <i>Combined out-of-pocket maximum includes deductible and applies to medical and prescription drug expenses.</i>	HSP Option 1	<i>Per Individual: \$3,000 Per Family: \$6,000</i>	<i>Per Individual: \$6,000 Per Family: \$12,000</i>
	HSP Option 2	<i>Per Individual: \$5,000 Per Family: \$10,000</i>	<i>Per Individual: \$10,000 Per Family: \$20,000</i>
	HSP Option 3	<i>Per Individual: \$6,000 Per Family: \$12,000</i>	<i>Per Individual: \$12,000 Per Family: \$24,000</i>

**Once one person in the family meets the individual out-of-pocket maximum, all covered expenses for that individual in the family will be covered at 100% for the rest of the Plan Year.*

Under the HSP, medical and prescription drug expenses both count toward the deductible and out-of-pocket maximum. Please note, however that:

- In-Network preventive medical care and all *preventive generic drugs* and insulin on the HSP Preventive Therapy Drug List are covered at 100%.
- For *preventive brand drugs* on the HSP Preventive Therapy Drug List, the deductible is waived and you pay 20% of the full discounted cost in coinsurance; the amount you pay in coinsurance goes toward the out-of-pocket maximum.
- *Specialty drugs* on the HSP Preventive Therapy Drug List are covered at a \$100 copayment and are not subject to the deductible.
- *All other specialty drugs* are covered at a \$100 copayment after the deductible is met.

Even though CVS Caremark administers your prescription drug coverage, your non-preventive prescription drug expenses count toward your medical option's deductible and out-of-pocket maximum. Further, if you're covering yourself and any dependents, you must reach the full amount of the family deductible before the plan pays benefits at 80% for in-network care or 50% for out-of-network care (unless the deductible doesn't apply—such as for Participating Provider preventive medical care and preventive medications).

OVERVIEW OF THE HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is a special savings account that lets you set aside money to pay for eligible health care expenses — now or anytime in the future. The HSA is an interest-bearing account that you can fund with pre-tax contributions made through payroll deduction or directly through the HSA Administrator, ConnectYourCare.

You may open your HSA when you enroll in the HSP; however, you cannot open an HSA if:

- You are enrolled in Medicare;
- You are covered by any other health care plan, including a Health Reimbursement Account or Flexible Spending Account; or
- You can be claimed as a dependent on someone else's federal tax return, except for your legal spouse.

Contributing to your HSA

You and CVS may contribute to your HSA. For 2016/2017, CVS will make a tax-free contribution to your HSA based on your annual base salary and whether you cover yourself only or yourself and any dependent, as noted below.

Annual Base Salary	Annual Contribution		Semi-Annual Contribution	
	Individual	Family	Individual	Family
\$35,000 or less	\$1,000	\$2,000	\$500	\$1,000
\$35,001 - \$80,000	\$750	\$1,500	\$375	\$750
\$80,001 - \$150,000	\$500	\$1,000	\$250	\$500
Greater than \$150,000	\$250	\$500	\$125	\$250

Note: Annual contributions shown are for enrollment for the full Plan Year of June 1 through May 31.

The CVS contribution is made semi-annually, each June and December in which you participate in the HSP.

Keep in Mind

To receive the CVS contribution, you must open your HSA with ConnectYourCare, the HSA Administrator for CVS, when you enroll in the HSP. HSA Bank is the custodial bank that ConnectYourCare partner with for your HSA account. HSA Bank is the custodial bank that ConnectYourCare partners with for your HSA account. Opening an HSA is quick and easy to do, and you don't need to make a deposit to open an account. You can also open an HSA with another institution instead of ConnectYourCare; however, you will not be able to receive CVS contributions or make pre-tax payroll contributions unless you have an open ConnectYourCare HSA.

For the 2016 calendar year, the Internal Revenue Service (IRS) limits annual HSA contributions to \$3,350 for individuals and \$6,750 for families. Annual limits are indexed and increased each year. For 2017, the limits are \$3,400 for individuals and \$6,750 for families. Also, starting in the year in which you turn age 55, you can also make up to an extra \$1,000 annual catch-up contribution. There is no "use it or lose it" rule that applies to your HSA, so any balance left at the end of the year remains in your HSA, available for future expenses.

Using Your Account

When you have qualified health care expenses, you can pay the expenses out of pocket and save your HSA funds for future expenses. Or you can pay for the expenses using your HSA funds.

Qualified health care expenses are defined by the IRS and include your medical plan deductible and coinsurance payments. You can also use your HSA funds to pay for other qualified health-related care such as out-of-pocket dental and vision expenses.

A complete list of HSA-qualified health care expenses can be found at **www.irs.gov**. Click on “Forms and Publications,” then select IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans, and IRS Publication 502, Medical and Dental Expenses.

You should consult your tax adviser if you have any questions about qualified health care expenses or your HSA.

Keep in Mind

A Health Savings Account (HSA) is not considered a health and welfare plan and is not subject to ERISA requirements. The information in this SPD about the HSA is provided to help you understand how the HSA works but is not an SPD for the HSA.

HEALTH SAVINGS PLAN FEATURES

Deductible

The deductible is the part of covered expenses you pay each Plan Year before the HSP starts to pay benefits.

There are two levels of deductible:

- *Employee only (Individual)*: If you elect coverage for yourself only, you must meet the *Individual* deductible, shown under the **OVERVIEW OF THE HEALTH SAVINGS PLAN (HSP)**, before the plan begins to pay benefits each Plan Year.
- *Family*: If you elect coverage for yourself and your dependents, you must meet the *Family* deductible shown under the **OVERVIEW OF THE HEALTH SAVINGS PLAN (HSP)**. The HSP begins to pay benefits once the combined covered expenses of all family members reach the *Family* deductible.

The HSP has separate deductibles for Participating Provider and Non-Participating Provider care:

- Expenses that apply to the Participating Provider deductible do not apply toward the Non-Participating Provider deductible.

- Expenses that apply to the Non-Participating Provider deductible do not apply toward the Participating Provider deductible.

Coinsurance

Once you meet your deductible, the HSP begins paying benefits for covered expenses. The portion paid by the HSP, as shown under the **OVERVIEW OF THE HEALTH SAVINGS PLAN (HSP)** and in the **BENEFIT HIGHLIGHTS**, is the plan's coinsurance. When the plan's coinsurance is less than 100%, you pay the balance. The part you pay is called your coinsurance.

The HSP has different coinsurance levels for Participating Provider and Non-Participating Provider care for each type of covered expense, as reflected in charts contained under the **OVERVIEW OF THE HEALTH SAVINGS PLAN (HSP)** and in the **BENEFIT HIGHLIGHTS** sections of this SPD.

Out of Pocket Maximum

The HSP puts a limit on the amount you pay for covered expenses out of your own pocket each year, called the out-of-pocket maximum.

- *Individual*: The *Individual* out-of-pocket maximum applies separately to each covered person in the family. Once an individual reaches the *Individual* out-of-pocket maximum, the HSP pays 100% of that person's covered expenses for the rest of the Plan Year.
- *Family*: The *Family* out-of-pocket maximum applies to the family as a group. If you cover someone besides yourself, here's how your HSP option's family out-of-pocket-maximum will work:
 - Once a covered family member reaches the *individual* out-of-pocket maximum, the HSP will pick up 100% of the cost of covered expenses for that family member for the rest of the Plan Year. No further expense for that individual member will apply to Family out-of-pocket maximum
 - Expenses for all remaining covered family members will continue to count toward the *family* out-of-pocket maximum.

Following is an example of how the out-of-pocket maximum operates for a family:

Colleague enrolled in HSP 1 with \$3,000 Family Deductible & \$3,000 per individual out-of-pocket maximum (up to \$6,000 family limit. Example assumes all expenses are incurred in-network.

- *Satisfying the \$3,000 family deductible*
 - Member 1 accumulates \$1,000 of expenses towards the family deductible
 - Member 2 accumulates \$1,500 of expenses towards the family deductible

- Member 3 accumulates \$500 of expenses towards the family deductible
- *Satisfying the \$3,000 / \$6,000 out-of-pocket maximums*
 - Member 2 incurs a \$10,000 claim; 80% coinsurance applies – Member pays \$1,500; individual out-of-pocket maximum is met
 - $\$10,000 \times 20\% \text{ member coinsurance} = \$2,000$
 - $\$1,500 \text{ of individual expenses incurred towards family deductible} + \$2,000 = \$3,500 > \$3,000 \text{ per individual out-of-pocket maximum}$
 - Member pays \$1,500 (total of \$3,000 in expenses) and satisfies the maximum; plan pays remainder of claim and future expenses incurred by this family member
 - $\$3,000 \text{ family deductible} + \$1,500 = \$4,500 < \$6,000 \text{ family out-of-pocket limit}$
 - Then, Member 1 incurs a \$2,000 claim; 80% coinsurance applies – Member pays \$400; neither individual or family out-of-pocket maximum are met
 - $\$2,000 \times 20\% \text{ member coinsurance} = \400
 - $\$1,000 \text{ of individual expenses incurred towards family deductible} + \$400 = \$1,400 < \$3,000 \text{ per individual out-of-pocket maximum}$
 - $\$4,500 \text{ of family expenses incurred} + \$400 = \$4,900 < \$6,000 \text{ family out-of-pocket limit}$
 - Then, Member 3 incurs a \$7,500 claim; 20% coinsurance applies – Member pays \$1,100; family out-of-pocket maximum is met
 - $\$7,500 \times 20\% \text{ member coinsurance} = \$1,500$
 - $\$500 \text{ of individual expenses incurred towards family deductible} + \$1,500 = \$2,000 < \$3,000 \text{ per individual out-of-pocket maximum}$
 - $\$4,900 \text{ of family expenses incurred} + \$1,500 = \$6,400 > \$6,000 \text{ family out-of-pocket limit}$
 - Member pays \$1,100 and the family maximum is satisfied; plan pays remainder of family's expenses

Both medical and CVS Caremark prescription drug plan expenses are applied to the out-of-pocket maximum. The HSP has separate out-of-pocket maximums for Participating Provider and Non-Participating Provider care:

- Expenses that apply to the Participating Provider out-of-pocket maximum do not apply toward the Non-Participating Provider out-of-pocket maximum.
- Expenses that apply to the Non-Participating Provider out-of-pocket maximum do not apply toward the Participating Provider out-of-pocket maximum.

Certain expenses do not apply toward the out-of-pocket maximum:

- Expenses over the Eligible Charge or Maximum Allowance;
- Penalties, including any additional out-of-pocket expenses resulting from noncompliance with the provisions of the Utilization Review Program and/or the Behavioral Health Care Unit; and
- Charges for services and supplies that are not covered by the Plan.

A Qualifying Event May Affect Your Plan Deductible and Out-of-Pocket Maximum

Change from Individual to Family Coverage

If you enroll in the HSP for Employee Only (*Individual*) coverage and later experience a qualifying event during the Plan Year that results in you adding one or more dependents, your coverage level, deductible and out-of-pocket maximum will change from *Individual* to *Family*. When the change to *Family* coverage occurs, amounts you met toward your *Individual* deductible and out-of-pocket maximum (as of the date of the change) will be applied to your new *Family* deductible and out-of-pocket maximum. As of the date of the change, your covered expenses will apply toward meeting both your *Family* deductible and *Individual* and *Family* out-of-pocket maximum.

Change from Family to Individual Coverage

If you enroll in the HSP for *Family* coverage and cover yourself and one or more dependents and later experience a qualifying event during the Plan Year that results in you dropping all your covered dependents from coverage, your coverage level, deductible and out-of-pocket maximum will change from *Family* to *Individual*. When this happens, only your individual expenses incurred while you were enrolled in *Family* coverage will apply to your new *Individual* deductible and out-of-pocket maximum. Your dependents' expenses that were applied to the *Family* deductible will not count towards your new *Individual* deductible and out-of-pocket maximum.

Example of Family to Individual Coverage:

- A mother and child are enrolled in the HSP 1 with *Family* coverage which has a *Family* deductible of \$3,000.
 - The mother has accumulated \$1,000 towards their *Family* plan deductible

- The child has accumulated \$500 towards the *Family* plan deductible
- Together, they have satisfied \$1,500 towards the *Family* plan deductible
- If the child has a qualifying event and is no longer eligible for dependent coverage, the mother's plan will change from *Family* coverage to *Individual* coverage, and as a result, only the \$1,000 that she has accumulated will be credited to her *Individual* plan deductible. The \$500 accumulated by her child will not be credited to her *Individual* plan deductible.

PARTICIPATING PROVIDER AND NON-PARTICIPATING PROVIDER BENEFITS

When you need medical care, you have a choice. You can select a doctor or facility that belongs to the network (a participating provider) or one that does not belong (a non-participating provider).

- If you use a *Participating Provider*, you'll pay less out of your own pocket for your care. You won't have to fill out claim forms, because your Participating Provider will file claims for you.
- if you use a *Non-Participating Provider*, you'll pay more out of your own pocket for your care. You may be required to file your own claims and you must make the telephone call required for precertification. (See Utilization Review Program for more information.)

The **BENEFIT HIGHLIGHTS** section of this SPD shows how the HSP's level of coverage differs when you use Participating versus Non-Participating Providers. In most cases, you save money when you use Participating Providers.

A directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at www.bcbsil.com/cvs for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by Blue Cross and Blue Shield of Illinois 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 CVS 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 the Participating Provider Option will be greater when you use the services of a Participating Provider.

Primary Care Physician (PCP)

While you are not required to choose a primary care physician (PCP), you and each covered member of your family have the option of selecting an internist, family care practitioner, general practitioner or pediatrician (for your children) to

serve as your regular PCP. A PCP can be your personal health care manager. He or she gets to know you and your special needs and problems, and can recommend a specialist when you need care that he or she can't provide. This can be very helpful, since it's often hard to choose the right specialist.

Specialists

Specialists are doctors such as oncologists, cardiologists, allergist, neurologists and podiatrists, to name a few. When you need specialty care, you can make an appointment directly with any licensed specialist. No referral is required. Remember, you'll pay less out of your pocket when you use a Participating Provider.

HEALTH CARE REFORM NOTICE– CHOICE OF PROVIDER

If a plan generally requires or allows you to designate a primary care physician, you have the right to designate any primary care physician who participates in the network and is available to accept you or your family as patients. If a primary care physician selection is required, BCBS IL may designate a primary care physician automatically until you make the designation. For information on how to select a primary care physician and a list of participating providers, contact BCBS IL at the number on your ID card.

If the plan allows for the designation of a primary care physician for a child, you may designate a pediatrician as the primary care physician.

If the plan covers obstetric or gynecological care and requires the designation of a primary care physician, you do not need prior authorization from BCBS IL to access obstetrical or gynecological care from a network physician who specializes in such care. The network physician, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics and gynecology, contact BCBS IL at the number on your ID card.

BENEFIT HIGHLIGHTS

For all three HSP options, services are covered as follows (see How the Plan Works section for details on deductible and OOP maximums). Any benefit maximums apply to Participating and Non-Participating provider services combined.

Percentage of Eligible Expenses Plan Pays		
<i>Service</i>	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Hospital Care		
Inpatient Services	80% after deductible	50% after deductible
Outpatient Services	80% after deductible	50% after deductible
Alternatives to Inpatient Care		
Coordinated Home Care <i>Limited to 80 visits per Plan Year</i>	80% after deductible	50% after deductible
Hospice Care	80% after deductible	50% after deductible
Skilled Nursing Facility Care <i>Limited to 120 days per Plan Year</i>	80% after deductible	50% after deductible
Behavioral Health Services		
Autism Spectrum Disorder Treatment (Including ABA) <i>Physical, Occupational, and Speech therapy is covered for treatment of ASD, subject to plan maximums. ABA Therapy is covered for a diagnosis of autism if performed by an eligible BCBA provider.</i>	80% after deductible	50% after deductible
Mental Illness Inpatient Services <i>(Inpatient, Residential Treatment Center, Partial Hospitalization Program)</i>	80% after deductible	50% after deductible
Substance Use Disorder Inpatient Treatment <i>(Inpatient, Residential Treatment Center, Partial Hospitalization Program)</i>	80% after deductible	50% after deductible

Percentage of Eligible Expenses Plan Pays		
Service	Participating Provider	Non-Participating Provider
Mental Illness Outpatient Services <i>(Outpatient professional, Intensive Outpatient)</i>	80% after deductible	50% after deductible
Substance Use Disorder Outpatient Treatment <i>(Outpatient professional, Intensive Outpatient)</i>	80% after deductible	50% after deductible
Outpatient Care		
Allergy Injections	80% coverage, no deductible	50% after deductible
Allergy Testing	80% after deductible	50% after deductible
Diabetes Education <i>Limited to 13 sessions</i>	80% after deductible	50% after deductible
Hearing Examination <i>Limited to 1 exam per year</i>	80% after deductible	Not covered
Nutritional Counseling <i>First 3 visits covered; next 3 visits require diagnosis</i>	80% after deductible	50% after deductible
Other Walk-in Clinics	80% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible
Physician Office Visits (PCP & Specialist)	80% after deductible	50% after deductible
X-Ray and Lab Tests — Preventive	100% coverage, no deductible	Not covered
— Diagnostic	80% after deductible	50% after deductible
X-Ray: Hi-tech radiology - CT Scans, Pet Scans, MRI, etc.	80% after deductible	50% after deductible (Non-notification penalty of \$500)

Percentage of Eligible Expenses Plan Pays		
<i>Service</i>	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Emergency Care		
Ambulance	80% after deductible	80% after participating provider deductible
Emergency Medical Care - Office Visit	80% after deductible	80% after participating provider deductible
Emergency Room <i>Non-Emergency use of Emergency Room is not covered</i>	80% after deductible	80% after participating provider deductible
Urgent Care	80% after deductible	80% after participating provider deductible
Preventive Care		
Bone Density Screening — Preventive <i>Baseline screening recommended for women under age 65; one screening recommended every 2 years for women 65 and older or earlier if due to family history</i>	100% coverage, no deductible	Not covered
— Diagnostic	80% after deductible	50% after deductible
Colonoscopy — Preventive <i>Recommended for those age 50 and over or earlier if due to family history</i>	100% coverage, no deductible	Not covered
— Diagnostic	80% after deductible	50% after deductible

Percentage of Eligible Expenses Plan Pays		
<i>Service</i>	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Mammogram — Preventive <i>1 baseline mammogram recommended for those age 35-39; one per Plan Year recommended for those age 40 and older or earlier if due to family history</i> — Diagnostic	100% coverage, no deductible 80% after deductible	Not covered 50% after deductible
OB/GYN Exam <i>Limited to one exam per Plan Year; includes pap smear</i>	100% coverage, no deductible	Not covered
Routine Physical Exam (Adults) <i>Limited to one exam per Plan Year</i>	100% coverage, no deductible	Not covered
Prostate Screening — Preventive <i>One PSA and DRE recommended per Plan Year for men age 45 and over, or earlier, if due to family history.</i> — Diagnostic	100% coverage, no deductible 80% after deductible	Not covered 50% after deductible
Screening for Abdominal Aortic Aneurysm <i>One-time screening for men over age 65 with a prior history of tobacco use</i>	100% coverage, no deductible	Not covered
Screening for Routine Lung Cancer <i>One-time screening for men and women over age 55 with a prior history of tobacco use</i>	100% coverage, no deductible	Not covered

Percentage of Eligible Expenses Plan Pays

<i>Service</i>	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Screening and Counseling — Obesity	100% coverage, no deductible	Not covered
— Use of tobacco products	100% coverage, no deductible	Not covered
— Misuse of alcohol or drugs	100% coverage, no deductible	Not covered
— Women’s health screenings & counseling	100% coverage, no deductible	Not covered
Well Child Care Visits <i>7 exams from birth to 12 months; 3 exams from 13 months to 24 months; 3 exams from 25 months to 36 months; 1 exam per Plan Year thereafter until age 18</i>	100% coverage, no deductible	Not covered
Family Planning		
Abortion Services — Elective and induced	80% after deductible	50% after deductible
— Multi-fetal pregnancy reductions (MFPR)	80% after deductible	50% after deductible
Breast Pumps and Supplies — Manual Pumps	100% coverage, no deductible	50% after deductible
— Electric Pumps <i>1 pump per birth</i>	100% coverage, no deductible	50% after deductible
— Hospital Grade Pumps <i>Covers a rental for up to 12 months after birth</i>	100% coverage, no deductible	50% after deductible
Contraceptive Counseling	100% coverage, no deductible	Not covered

Percentage of Eligible Expenses Plan Pays		
<i>Service</i>	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Contraceptive Devices and Injectibles <i>provided by your physician</i> - generic and brand-name injectible contraceptives with no generic equivalent - brand-name injectible contraceptives	100% coverage, no deductible 80% coverage, no deductible	Not covered Not covered
Infertility Services (<i>physician's office or outpatient facility</i>) — Diagnosis and treatment of the under-lying cause of infertility — Ovulation induction, artificial insemination and advanced reproductive technologies (ART) <i>up to a per person lifetime maximum of \$10,000</i>	80% after deductible 80% after deductible	50% after deductible 50% after deductible
Lactation Counseling	100% coverage, no deductible	100% coverage, no deductible
Routine Maternity Care (physician services) *	Initial visit to confirm pregnancy, delivery and post-natal care covered at 80% after deductible Prenatal care covered at 100%, no deductible	50% after deductible
Voluntary Sterilization (men)	80% after deductible	50% after deductible
Voluntary Sterilization (women)	100% coverage, no deductible	50% after deductible

Percentage of Eligible Expenses Plan Pays		
<i>Service</i>	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Therapy Services		
Cardiac and Pulmonary Rehabilitation	80% after deductible	50% after deductible
Chiropractic and Osteopathic Manipulation <i>Limited to 15 visits per Plan Year</i>	80% after deductible	50% after deductible
Occupational and Physical Therapy Services <i>Limited to 60 visits combined per Plan Year</i>	80% after deductible	50% after deductible
Speech Therapy <i>Limited to 40 visits per Plan Year</i>	80% after deductible	50% after deductible
Other Covered Services		
Anesthesia	80% after deductible	50% after deductible
Bariatric Surgery (including Lap Band, Gastric Sleeve and Gastric Bypass procedures) <i>Limited to one surgery per lifetime; coverage limited to Blue Distinction Centers (BDC); Travel benefit available and limited to \$10,000 per lifetime</i>	80% after deductible <i>(Blue Distinction Center only)</i>	Not covered
Blood Transfusions	80% after deductible	50% after deductible
Chemotherapy	80% after deductible	50% after deductible
Dialysis	80% after deductible	50% after deductible
Durable Medical Equipment <i>No coverage for certain diabetic equipment & supplies available through CVS Caremark prescription drug plan. Foot Orthotics covered and subject to medical necessity.</i>	80% after deductible	50% after deductible
Enteral Nutrition	80% after deductible	50% after deductible

Percentage of Eligible Expenses Plan Pays		
Service	Participating Provider	Non-Participating Provider
Eye Care <i>Physician's services for eye care conditions including pink eye, retinal detachment and cataracts- no coverage for routine vision exams.</i>	80% after deductible	50% after deductible
Human Organ Transplants <i>Benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will only be provided when performed at a Blue Distinction Center for Transplants (BDCT); Travel benefit available and limited to \$10,000 per lifetime</i>	80% after deductible	Not covered
Oral Surgery and TMJ Treatment	80% after deductible	50% after deductible
Prosthetic Appliances	80% after deductible	50% after deductible
Transgender Surgery <i>Limited to a lifetime maximum of \$75,000 per person.</i>	80% after deductible	50% after deductible
Telemedicine services (MD Live)	80% after deductible	Not covered
Wigs For hair loss due to injury, disease, or treatment of a disease are covered. Limited to \$1,000 per plan year	80% after deductible	50% after deductible

* The benefits shown are for routine maternity care and services provided by your OB/GYN, including routine prenatal care, delivery services and postnatal care. Additional services such as laboratory tests and care that is required due to complications of pregnancy are not considered routine maternity care.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY AND ENROLLMENT 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 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.

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.

Partial Hospitalization Treatment

No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield of Illinois.

Coordinated Home Care

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

You are entitled to benefits for 80 visits in a Coordinated Home Care Program per benefit period.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider benefits will be provided at 80% of the Eligible Charge after you have met your deductible, unless otherwise specified in this benefit booklet. 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-Participating Providers

When you receive Inpatient Covered Services from a Non-Participating Provider benefits will be provided at 50% of the Eligible Charge after you have met your 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. Please refer to the DEFINITIONS section of this benefit booklet under "PROVIDER" for additional information regarding the various types of providers.

During an Inpatient Hospital admission to a Non-Participating Provider resulting from Emergency Medical Care, benefits will be provided at the Participating Provider level for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by Blue Cross and Blue Shield of Illinois to be serious and therefore not permitting your safe transfer to a Participating Hospital or other Participating Provider. For the portion of your Inpatient Hospital stay during which your condition is reasonably determined as not being serious and therefore permitting your safe transfer, benefits will be provided at the Non-Participating Hospital payment level.

In order for you to continue to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Participating 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

- Surgery and any related Diagnostic Service received on the same day as the Surgery
- Radiation Therapy Treatments
- Chemotherapy
- Electroconvulsive Therapy
- Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility

- Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
- Urgent Care
- Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
- Emergency Medical Care
- Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 80% of the Eligible Charge after you have met your deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Benefits for urgent care from a Participating Provider will be provided at 80% of the Hospital's Eligible Charge after you have met your deductible.

Non-Participating Providers

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 50% of the Eligible Charge after you have met your deductible. Benefits for urgent care from a Non-Participating Provider will be provided at 80% of the Hospital's Eligible Charge after you have met your deductible.

Emergency Care

Benefits for Emergency Care will be provided at 80% of the Eligible Charge when you receive Covered Services from either a Participating or Non-Participating Provider.

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

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which Blue Cross and Blue Shield of Illinois has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT

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.

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

For benefits to be available under the PHYSICIAN BENEFIT section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

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 plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

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

The following services are also part of your surgical benefits:

- Anesthesia 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.

- 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 performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
- Sterilization Procedures (even if they are elective).

Medical Care

Benefits are available for Medical Care visits when:

- you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Use Disorder Treatment Facility or
- you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
- 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 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 also 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 if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. 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. Diabetes education will be limited to thirteen sessions per benefit period.

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.

Emergency Accident Care

Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

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, provided the therapy is expected to:

- Significantly improve, develop or restore physical functions lost or impaired because of an acute illness, injury or surgical procedure; or
- Re-teach skills to improve independence in the activities of daily living.
- Occupational therapy does not include educational training or services designed to develop physical function, except when the therapy is for developmental delays (including Autism Spectrum Disorders), as medically appropriate.

The 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. The plan will also cover Physical and Occupational Therapy for developmental delays, including Autism Spectrum Disorders. Benefits for Outpatient Occupational Therapy and Physical Therapy will be limited to a combined maximum of 60 visits per benefit period.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician, provided the therapy is expected to significantly improve, develop or restore physical functions that were lost or impaired because of an acute illness, injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function, except when the therapy is for developmental delays (including Autism Spectrum Disorders), as medically appropriate.

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. The plan will also cover Physical and Occupational Therapy for developmental delays, including Autism Spectrum Disorders. Benefits for

Physical Therapy and Outpatient Occupational Therapy will be limited to a combined maximum of 60 visits per benefit period.

Chiropractic and Osteopathic Manipulation

Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 15 visits per benefit period.

Speech Therapy

Benefits will be provided for Speech Therapy when rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association, provided the therapy is to restore the loss of speech function or correct a speech impairment or dysfunction resulting from injury, sickness, stroke, cancer, developmental delays (including Autism Spectrum Disorders) or a congenital anomaly, or is needed following the placement of a cochlear implant, as medically appropriate.

Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. The plan will pay benefits for speech therapy only when the speech impediment or dysfunction results from injury, sickness, stroke, cancer, or development delays (including Autism Spectrum Disorders). Outpatient Speech Therapy benefits will be limited to a maximum of 40 visits per benefit period.

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.

Bone Mass Measurement and Osteoporosis

Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis. Preventive services are limited to 1 baseline screening for women under age 65 and one screening every 2 years for women 65 and older. There is no limit on diagnostic services.

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), bone screws, bolts, nails, plates and any other internal and permanent devices. 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.

Foot Orthotics are covered and subject to medical necessity guidelines with a physician's prescription.

This coverage excludes certain diabetic equipment and supplies which are available through the CVS Caremark prescription drug plan.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, implants, injectibles 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.

Contraceptive devices, implants and generic and brand-name injectibles with no generic equivalent provided by a Participating Physician will be covered at 100% of the Maximum Allowance. However, brand-name injectibles with a generic equivalent provided by a Participating Physician will be covered at 80% of the Maximum Allowance. The deductible will not apply. Benefits will not be provided if services are provided and billed by a Non-Participating Physician.

Abortion Services

Elective and induced abortions are covered including Multi-fetal pregnancy reductions (MFPR).

Prosthetic Appliances

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

- they are required to replace all or part of an organ or tissue of the human body, or
- 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 other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Nutritional Counseling

Nutritional Counseling is covered up to six nutritionist visits per year. It must be performed by a registered dietitian/nutritionist. Nutritional counseling visits may be covered for healthy individuals seeking nutritional information or desiring weight loss or for the purpose of treating an illness. A diagnosis is required for visits four through six.

Routine Hearing Examination

Benefits will be provided for one routine hearing examination every year with Participating Providers.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by Blue Cross and Blue Shield of Illinois and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

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 80% of the Maximum Allowance after you have met your deductible, unless otherwise specified in this benefit booklet. 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 Blue Cross and Blue Shield of Illinois's benefit payment and the Provider's charge to you.

Non-Participating Provider

When you receive any of the Covered Services described in this PHYSICIAN BENEFIT section from a Non-Participating Provider, benefits will be provided at 50% of the Maximum Allowance after you have met your deductible.

Emergency Care

Benefits for Emergency Care will be provided at 80% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your Participating Provider deductible.

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.

- Blood and blood components
- Ambulance Transportation (Ground, Air or Water)—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
- Investigational Services and Supplies related to Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA). Such trials include those that are federally funded, trials conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA) or drug trials exempt from having an investigational new drug application.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.

When you receive Other Covered Services from a Participating or Non-Participating 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.

DENTAL RELATED SERVICES

The HSP covers treatment of the mouth, jaws and teeth that is medical in nature, including surgery needed to:

- Treat a fracture, dislocation or wound;
- To remove cysts, tumor or other diseased tissues;
- Remove teeth that are partly or completely impacted in the jaw bone;
or
- Alter the jaw, jaw joints or bite relationships when appliance therapy cannot result in functional improvement.

Dental implant surgery that is required due to loss of sound natural teeth resulting from treatment of dislocations, facial and oral wounds/lacerations, removal of cysts or tumors of the jaws or facial bones or other diseased tissues, or the result of previous therapeutic process for a Covered Medical Condition is covered under the plan. The plan will also cover implants due to the absence of teeth related to congenital defects and anomalies when they result in a functional impairment.

The plan provides benefits for replacement of teeth as a result of a non-biting injury. Sound natural teeth are defined as teeth that were stable, functional, free from decay and advanced periodontal disease, and in good repair at the time of the accident or removal or loss due to disease conditions. A disease condition does not include periodontal disease, tooth decay, severe cavities, or general damage caused by biting or chewing. Charges to remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing are not covered medical expenses.

The plan covers the replacement of teeth whether accomplished by fixed or removable prostheses or by surgical placement of a dental implant body. In situations where replacement of the tooth/teeth is accomplished by dental implants, the dental crown is also a covered medical expense. Dental implants required due to the removal of teeth due to periodontal therapies and subsequent oral rehabilitation are not covered under the medical plan. All other treatment options must be exhausted.

The HSP also covers:

- Non-surgical treatment of infections or diseases (this does not include those of or related to the teeth)
- Dental work, surgery and orthodontic treatment to remove, repair, replace, restore or reposition natural teeth damaged or lost due to injury or disease. Any such teeth must be stable, free from decay and firmly attached at the time of injury or disease. Such dental work must be completed within 12 months of the injury or loss due to disease.

If crowns, dentures, bridgework or in-mouth appliances are installed due to injury or disease, the plan includes charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown to repair a damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

TELEMEDICINE SERVICES

Telemedicine is a service through MD Live that allows members to access a group of medical providers via phone or internet. The deductible and coinsurance applies for in-network only. Out-of-network is not applicable.

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 the following transplants are the same as your benefits for any other condition when you receive services from a Participating Provider. Benefits will not be provided if you receive services from a Non-Participating Provider.

- Cornea
- Kidney
- Bone Marrow
- Heart Valve
- Muscular-skeletal
- Parathyroid

Benefits for the following transplants will only be provided when performed at a Blue Distinction Center for Transplants (BDCT).

- Heart
- Lung
- Heart/lung
- Liver
- Pancreas
- Pancreas/kidney

Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact Blue Cross and Blue Shield of Illinois by telephone before your transplant Surgery has been scheduled. Blue Cross and Blue Shield of Illinois will furnish you with the names of Hospitals which have Blue Cross and Blue Shield of Illinois approved Human Organ Transplant Programs. Benefits are available to both the recipient and donor of any covered transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in 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 described in 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.
- Transportation and lodging, as described under Travel and Lodging Expenses in Connection with Transplants and Bariatric Surgery later in this section.

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 Blue Cross and Blue Shield of Illinois 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

Benefits will be provided for the following Covered Services and will not be subject to any deductible, Coinsurance, Copayment or maximum when such services are received from a Participating Provider:

- 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; and
- with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

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

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbsil.com/cvs or contact customer service at the toll-free number on your identification card.

Examples of covered services included are routine annual physicals, immunizations, well child care, cancer screenings, mammograms, bone density tests, screenings for prostate cancer and colorectal cancer, and healthy diet counseling and obesity screenings/counseling. See **BENEFIT HIGHLIGHTS (Preventive Care)** section of this SPD for more examples of covered services.

Examples of covered immunizations included are Diphtheria, Haemophilus influenza type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, rubella, Tetanus, Varicella and other immunization that is required by law for children.

No benefits will be provided for Preventive services received from a Non-Participating Provider.

Well Child Care

Benefits will be provided for Covered Services provided by a Physician to children under age 18, even though they are not ill. Benefits will be limited to the following services:

- routine diagnostic medical procedures;

- routine diagnostic tests.

The following limitations apply to Well Child Care visits:

- 7 exams from birth to 12 months;
- 3 exams from 13 months to 24 months;
- 3 exams from 25 months to 36 months; and
- 1 exam per Plan Year thereafter until age 18.

Benefits for Well Child Care received from a Participating Provider will be provided at 100% of the Maximum Allowance. The deductible will not apply.

No benefits will be provided for Well Child Care services received from a Non-Participating Provider.

Colonoscopies, Mammograms, Pap Smears & Bone Densitometry

- Preventive Screenings are covered at 100% for Participating Providers only. The deductible will not apply.
- Diagnostic screenings are covered at 80% for Participating Providers and 50% for Non-Participating Providers after the deductible is satisfied.

SKILLED NURSING FACILITY CARE

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

- Bed, board and general nursing care.
- 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 a Participating Skilled Nursing Facility will be provided at 80% of the Eligible Charge after you have met your deductible.

You are entitled to benefits for 120 days of care in a Skilled Nursing Facility per benefit period.

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.

Benefits for services rendered by a Participating Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your 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) 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:
 - self care and feeding,
 - pragmatic, receptive and expressive language,
 - cognitive functioning,
 - applied behavior analysis (ABA),
 - intervention and modification,
 - motor planning, and
 - sensory processing.

BARIATRIC SURGERY

Benefits for Covered Services received for bariatric Surgery (including Lap Band, Gastric Sleeve and Gastric Bypass procedures) will be limited to one surgery per lifetime and services must be performed at a Blue Distinction Center (BDC). Travel and lodging benefits may also be provided in connection with Bariatric Surgery. See the TRAVEL AND LODGING EXPENSES IN CONNECTION WITH TRANSPLANTS AND BARIATRIC SURGERY section for additional detail.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center.

MENTAL ILLNESS SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of Mental Illness disorders. Inpatient benefits for these Covered Services will also be provided for the diagnosis and treatment of Inpatient Mental Illness 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.

MATERNITY SERVICES

Your benefits for Maternity Service are available whether you have Individual Coverage or Family Coverage. Benefits will be provided at 100% for prenatal visits after the initial visit to confirm pregnancy. Delivery and post-natal care are covered at 80% after the deductible when services are provided by a Participating Provider. 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 and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery.

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother 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 Blue Cross and Blue Shield of Illinois for prescribing a length of stay less than 48 hours (or 96 hours).

INFERTILITY TREATMENT

The HSP covers the diagnosis and/or treatment of underlying causes of infertility, when provided by or under the direction of a physician. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to 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:

- a diagnosis of male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
- 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 sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to:

- oral contraceptives,
- chemicals,
- physical or barrier contraceptives,
- natural abstinence or
- voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits 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, including, but not limited to:

- in-vitro fertilization (IVF),
- ovulation induction and controlled ovarian stimulation,
- uterine embryo lavage,
- embryo transfer,
- artificial insemination,
- intrauterine insemination (IUI),
- gamete intrafallopian tube transfer (GIFT),
- zygote intrafallopian tube transfer (ZIFT),
- low tubal ovum transfer, and
- intracytoplasmic sperm injection (ICSI), and
- needle biopsy or fine needle aspiration of the testis to aspirate sperm.

Benefits for treatments that include oocyte retrievals will be provided only when:

- you have been unable to attain 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; *and*
- you have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

The HSP also covers the following:

- 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.
- Care of a person covered by the plan who is participating in a donor IVF program, including fertilization and culture.
- Fertility preservation via IVF for colleagues and their covered spouses that will undergo planned cancer or other medical treatments that are likely to result in infertility. The plan covers collection of sperm, ovulation induction, retrieval of eggs, IVF and cryopreservation (freezing only; storage is not covered).
- Artificial insemination of a female carrier for infertile male members without a female partner. If the female does not conceive following six cycles of insemination, no further coverage is provided unless a different surrogate is used, and then only for an additional six months of insemination with the covered male member's sperm. However, the cost of any surrogate fees, as well as the cost of care associated with pregnancy, deliver and any complications, is *not* covered during the pregnancy/delivery.

Special Limitations

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

Your benefits for the treatment of infertility are subject to a per person lifetime maximum of \$10,000.

Benefits will *not* be provided for the following:

- Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
- Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
- Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
- Non-medical costs of an egg or sperm donor.

- Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield of Illinois.
- Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
- Infertility treatment rendered to dependent children.

TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION AND RELATED DISORDERS

Benefits are provided for the diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a physician. Coverage includes medically necessary treatment required as a result of an accident, trauma, a congenital anomaly, developmental defect, or pathology. This plan does not cover services for the evaluation and treatment of TMJ when the services are considered dental in nature, including oral appliances.

TRAVEL AND LODGING EXPENSES IN CONNECTION WITH TRANSPLANTS AND BARIATRIC SURGERY

For applicable transplants and bariatric surgery that must be performed only at a Blue Distinction Center (BDC), benefits will be provided for transportation and lodging for you and a companion. If the patient is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the patient and two companions. For benefits to be available, you must reside more than 75 miles from the Blue Distinction Center where the surgery will be performed.

Benefits for transportation and lodging are limited to a combined lifetime maximum of \$10,000. Reimbursement of expenses incurred by the patient and companion for hotel lodging away from home is reimbursed at a rate of \$50 per night per person (or \$100 per night total). If the patient is a child, lodging for two parents or guardians is permitted. . Reimbursement will require submission of a qualifying receipt. Meals are not allowed to be included in lodging expenses per IRS Code 213(d)/Publication 502.

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:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- 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; and
- Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

(GENDER REASSIGNMENT) SURGERY

Your benefits for gender reassignment surgery are the same as your benefits for any other condition. Benefits will be provided for Covered services rendered to persons age 18 and over. Benefits for gender reassignment surgery are limited to a lifetime maximum of \$75,000 per member.

To be covered, the following conditions must *all* be met:

- Reached the age of at least 18 years;
- The capacity to make a fully informed decision and to consent for treatment;
- Been diagnosed with persistent, well-documented gender dysphoria;
- Lived continuously for at least 12 months in the gender role (real life experiences) that is consistent with the preferred gender, without periods of time returning to the individual's original gender;
- Completed at least 12 months of continuous hormonal sex reassignment therapy of either male-to-female (MtF) or female-to-male (FtM);
- Undergone a urological examination to identify and treat abnormalities of the genitourinary tract;
- Been an active participant in a recognized gender identity treatment program; and
- Referrals for surgery from the individual's qualified mental health professionals competent in the assessment and treatment of gender dysphoria, which include:
 1. One referral required for breast/chest surgery that is mastectomy, chest reconstruction, or breast augmentation; AND
 2. One independent referral required for genital surgery that is hysterectomy, salpingoophorectomy, orchiectomy, and/or other genital reconstructive procedures.

Male to Female (MtF) procedures that **may be considered as part of the GRS** when the benefit coverage allows services for GRS for an individual who has met the above selection criteria include:

- Clitoroplasty,
- Coloproctostomy,
- Colovaginoplasty,
- Labioplasty,
- Orchiectomy,
- Penectomy,
- Penile skin inversion,
- Repair of introitus,
- Vaginoplasty with construction of vagina with graft, and/or
- Vulvoplasty

Female to Male (FtM) procedures that **may be considered as part of the GRS** when the benefit coverage allows services for GRS for an individual who has met the above selection criteria include:

- Hysterectomy,
- Metoidioplasty,
- Phalloplasty,
- Placement of an implantable erectile prostheses,
- Placement of testicular prostheses,
- Salpingo-oophorectomy,
- Scrotoplasty,
- Subcutaneous mastectomy,
- Vaginectomy, as known as colpectomy,
- Urethroplasty, and/or
- Urethromeatoplasty.

The HSP may also provide coverage for certain secondary gender characteristic services (masculinizing or feminizing) that may be considered eligible for treatment of gender dysphoria if deemed a medically necessary part of the overall gender reassignment treatment, such as facial reconstruction and hair removal procedures/services.

The following procedures or services **are considered cosmetic or not medically necessary** when used to improve the gender specific appearance of an individual who is planning to undergo or has undergone GRS, including but not limited to:

- Collagen injections, and/or
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.

COVERAGE OUTSIDE THE U.S.

The HSP covers you if you become sick or injured while traveling outside the U.S. and need urgent or emergent care. Covered services received outside of the U.S. are subject to deductible and will be paid at the in-network reimbursement level, based on billed charges. Generally, you must pay the cost incurred for covered services and then file a claim for reimbursement with BCBSIL.

Like your passport, always carry your Blue Cross and Blue Shield of Illinois (BCBSIL) ID card with you when you travel outside the United States (U.S.). Through the BlueCard Worldwide program, you have access to medical assistance services and doctors and hospitals in more than 200 countries and territories around the world. The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at 1-800-810-BLUE (2583) or by calling collect at 1-804-673-1177. Before you leave home, contact BCBSIL for coverage details, as your coverage outside the U.S. differs.

If the BlueCard Worldwide Service Center arranges your hospitalization, the hospital will file your claim *after* you pay the hospital for the out-of-pocket expenses you incurred. For outpatient and doctor care, or inpatient care not arranged through the BlueCard Worldwide Service Center, you will need to pay the health care provider and submit an international claim form with original bills. International claim forms are available from BCBSIL, the Service Center or on-line at www.bcbs.com/bluecardworldwide.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided 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:

- Coordinated Home Care;
- Medical supplies and dressings;
- Medication;
- Nursing Services - Skilled and non-Skilled;
- Occupational Therapy;
- Pain management services;
- Physical Therapy;
- Physician visits;
- Social and spiritual services; and
- Respite Care Service.

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

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

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.

UTILIZATION REVIEW PROGRAM

Blue Cross and Blue Shield of Illinois has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this plan. The Utilization Review Program requires a review of the following Covered Services **before** such services are rendered:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. Failure to obtain Preadmission/Admission Review for services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO NOTIFY. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

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 the plan as well as the Preexisting Condition waiting period, if any.

Whenever a non-emergency or non-maternity Inpatient Hospital admission is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call Blue Cross and Blue Shield of Illinois'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.

Skilled Nursing Facility and/or Coordinated Home Care 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 plan as well as the Preexisting Condition waiting period, if any.

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call Blue Cross and Blue Shield of Illinois's medical pre-notification

number. This call must be made at least one business day prior to the scheduling of the admission.

PREDETERMINATION REVIEW

Predetermination is a review by Blue Cross and Blue Shield of a medical procedure, treatment or test that has been recommended by your Physician to determine if it meets approved Blue Cross and Blue Shield medical policy guidelines.

A predetermination review can help you avoid unexpected out-of-pocket costs by finding out ahead of time if a recommended service will be covered by your health care plan. Predetermination 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. Predetermination is not required, but suggested for services that may be considered Experimental/Investigational.

Your doctor may order sophisticated and expensive diagnostic procedures to detect serious medical conditions such as cancer, heart disease and brain disorders. Examples of such procedures are Positron Emission Tomography (PET) scan, Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CT) scan.

Sometimes these procedures may not be considered "medically necessary" or there may be an equally effective test available at a lower cost. In this event, the cost for the more expensive procedure will not be covered by your medical plan benefits.

If your doctor orders a diagnostic procedure for you or a covered family member, you and/or your doctor are encouraged to obtain advance authorization from Blue Cross and Blue Shield of Illinois (BCBSIL).

To make a request for advance authorization or predetermination review, contact Blue Cross and Blue Shield of Illinois customer service toll free at 1-888-775-6481 and be prepared to provide the following information:

1. Group and subscriber identification numbers on the front of your ID card;
2. Medical procedure that has been recommended by your Physician with Current Procedural Terminology (CPT) code, if available;
3. Name, address and telephone number of the Physician who is recommending the service.

Blue Cross and Blue Shield may request more information from your Physician, such as your medical records. You and your Physician will both receive notification with a decision of your predetermination review from Blue Cross and

Blue Shield no later than 30 business days after Blue Cross and Blue Shield receives the request for predetermination review.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois 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 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 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 plan as well as the Preexisting Condition waiting period, if any.

Upon completion of the preadmission or emergency review, Blue Cross and Blue Shield of Illinois will send a letter to your Physician and/or the Hospital confirming that you or your representative called Blue Cross and Blue Shield of Illinois and that an approved length of service or length of stay was assigned.

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.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield of Illinois 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.

Blue Cross and Blue Shield of Illinois 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. Blue Cross and Blue Shield of Illinois'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 plan.

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

Remember the 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, Blue Cross and Blue Shield of Illinois will not pay for the hospitalization, services or supplies unless Blue Cross and Blue Shield of Illinois determines it to be Medically Necessary and a Covered Service under the 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 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 REVIEW PROCEDURE

The following information is required when you contact Blue Cross and Blue Shield of Illinois:

- the name of the attending and/or admitting Physician;
- the name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
- the scheduled admission and/or service date; and
- a preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, Blue Cross and Blue Shield of Illinois:

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

APPEAL PROCEDURE

If you or your Physician disagree with the determination of Blue Cross and Blue Shield of Illinois prior to or while receiving services, you may appeal that decision. You should call Blue Cross and Blue Shield of Illinois'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 call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
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 Blue Cross and Blue Shield of Illinois will not interfere with your relationship with any Provider. However, Blue Cross and Blue Shield of Illinois has established the Utilization 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.

Should you fail to notify Blue Cross and Blue Shield of Illinois as required in the Preadmission Review provision of this section, you will then be responsible for the first \$500 of the Out-of-Network Hospital or facility charges for an eligible stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable, as described in this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare primary and have secondary coverage provided under the plan.

BEHAVIORAL HEALTH CARE UNIT

Blue Cross and Blue Shield of Illinois's Behavioral Health Care Unit has been established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits, including Preauthorization 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. The Behavioral Health Care Unit has staff which includes Physicians, Psychologists, Clinical Social Workers and registered nurses.

Failure to contact the Behavioral Health Care Unit or to comply with the determinations of the Behavioral Health Care Unit may result in a reduction of benefits. The Behavioral Health Care 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.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO PREAUTHORIZE OR NOTIFY.

PREAUTHORIZATION REVIEW

Inpatient Hospital Preauthorization Review

Preauthorization 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 plan as well as the Preexisting Condition waiting period, if any.

In order to receive maximum benefits under the HSP, you or someone on your behalf must notify Blue Cross and Blue Shield no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorders has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

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 plan as well as the Preexisting Condition waiting period, if any.

In order to receive maximum benefits under the HSP, you must notify the Behavioral Health Care Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Participating and Non-Participating Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. The Behavioral Health Care Unit will obtain information regarding the 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 a service(s), in order to receive maximum benefits under this plan, an additional call must be made to the Behavioral Health Care Unit for an Emergency Mental Illness or Substance Use Disorder 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 plan as well as the Preexisting Condition waiting period, if any.

Upon completion of an Emergency Mental Illness or Substance Use Disorder Inpatient Hospital Admission Review or a Non-Emergency Mental Illness or Substance Use Disorder Preadmission Review,, the Behavioral Health Care Unit will send you a letter confirming that you or your representative called the Behavioral Health Care 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 Care 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 Care Unit Physician for review.

Outpatient Service Preauthorization

Outpatient service Preauthorization 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.

In order to receive maximum benefits under this Certificate for the following Outpatient services for the treatment of Mental Illness or Substance Use Disorders, you must Preauthorize the following Outpatient service(s) by calling Blue Cross and Blue Shield:

- Electroconvulsive therapy
- Intensive Outpatient Programs
- Repetitive Transcranial Magnetic Stimulation

- Psychological or neuropsychological testing in some cases. (Blue Cross and Blue Shield will notify your Provider if Preauthorization is required for these testing services.)

Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one business day prior to receiving the planned Outpatient service. Blue Cross and Blue Shield will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

BEHAVIORAL HEALTH CARE UNIT MEDICALLY NECESSARY DETERMINATION

The decision that a Mental Illness or Substance Use Disorder admission or an Outpatient service is not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Behavioral Health Care Unit. If the Behavioral Health Care Unit Physician concurs that the Inpatient Hospital admission or other health care service or supply does not meet the criteria for Medically Necessary care, 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 Care 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 Care 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 Care 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 plan.

In the event that the Behavioral Health Care Unit determines that all or any portion of an Inpatient Hospital admission or other health care service or supply is not Medically Necessary, Blue Cross and Blue Shield of Illinois will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that the HSP 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, Blue Cross and Blue Shield of Illinois will not pay for the hospitalization, services or supplies if the Behavioral Health Care Unit Physician decides they were not Medically Necessary.

BEHAVIORAL HEALTH CARE UNIT APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Behavioral Health Care Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Behavioral Health Care Unit and requesting an expedited appeal. The Behavioral Health Care 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 Care 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 Care Unit Physician, you may request an appeal in writing as outlined below.

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 Care 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 Blue Cross and Blue Shield of Illinois, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois, if you request an appointment in writing.

Within 30 days of receiving your request for review, Blue Cross and Blue Shield of Illinois 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 PREAUTHORIZE OR NOTIFY

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

Should you fail to Preauthorize or notify the Behavioral Health Care Unit as required in the Preauthorization Review provision of this section, you will then be responsible for the first \$500 of the Out-of-Network Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable to this benefit booklet.

CASE MANAGEMENT/ INDIVIDUAL BENEFITS MANAGEMENT PROGRAM (“IBMP”)

When you receive Covered Services for a complex mental health or substance use disorder condition, you may be contacted by a Behavioral Health case manager. Case managers (Clinical professional Counselors, Clinical Social Workers, Marriage and Family Therapists, and/or registered nurses) may help answer your questions about your condition, help you understand what to expect when you are discharged from the hospital to your home or to another care facility, provide additional resources to support you with your condition and help coordinate special care you may need.

In some cases, the case manager may offer an alternative treatment plan. If you and your Physician choose the alternative treatment plan, then alternative benefits may be provided as described in this plan.

In addition to the benefits described in this benefit booklet, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Participating Provider in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as Blue Cross and Blue Shield determines that the alternative services are Medically Necessary and cost-effective. The case manager will continue to be available for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this 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 this plan

MEDICARE ELIGIBLE MEMBERS

The provisions of the BEHAVIORAL HEALTH CARE UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the HSP.

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 AND ENROLLMENT 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 HSP is as follows:

- determine what the payment for a Covered Service would be following the payment provisions of this coverage and
- 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 plan.

When you have a Claim, you must send Blue Cross and Blue Shield of Illinois 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

The HSP does not cover all medical expenses; certain expenses are excluded. The list of excluded expenses in this section is representative, not comprehensive.

GENERAL EXCLUSIONS

- 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 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 do not meet accepted standards of medical and/or dental practice.
- Investigational Services and Supplies and all related services and supplies, except Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA). Such trials include those that are federally funded, trials conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA) or drug trials exempt from having an investigational new drug application. A life-threatening condition is any disease from which the likelihood of death is probable, unless the course of the disease is interrupted.
- 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.
- Immunizations, unless otherwise specified in this benefit booklet.

- Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this plan.
- Acupuncture or alternative medicine

BIOLOGICAL AND BIONIC

- Blood derivatives which are not classified as drugs in the official formularies.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

COSMETIC PROCEDURES

- 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.
- 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.

CUSTODIAL AND PROTECTIVE CARE

- Custodial Care Service.
- Long Term Care Service.
- Respite Care Service, except as specifically mentioned under the Hospice Care Program.
- Private Duty Nursing Service.
- 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).

DENTAL SERVICES RELATED TO THE TREATMENT OF TMJ

Dental services related to the treatment of TMJ including the following:

- In-mouth appliances, crowns, bridgework, dentures, tooth restorations or related fittings or adjustments - whether or not the purpose is to relieve pain.
- Root canal therapy.
- Routine tooth removal.
- Removal, repair, replacement, restoration or repositioning of teeth lost or damaged in the course of biting or chewing.
- Repair, replacement or restoration of fillings, crowns, dentures or bridgework.
- Non-surgical periodontal treatment.
- Dental cleaning, in-mouth scaling, planing or scraping.
- Myofunctional therapy. This is muscle training therapy or training to correct or control harmful habits.

EDUCATION AND TRAINING

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

FAMILY PLANNING AND MATERNITY

- Reversals of sterilization.

HEALTH EXAMS

- 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.

HOME AND MOBILITY

- 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.
- 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.

HOSPITALIZATION, SERVICES AND SUPPLIES WHICH ARE NOT MEDICALLY NECESSARY

No benefits will be provided for services which are not, in the reasonable judgment of Blue Cross and Blue Shield of Illinois, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of Blue Cross and Blue Shield of Illinois, 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 Blue Cross and Blue Shield of Illinois, 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 his family members.

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

Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois'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, BLUE CROSS AND BLUE SHIELD OF ILLINOIS WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

VISION AND HEARING

- 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.
- Routine vision exams
- Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet.

PRESCRIPTION DRUGS (INCLUDING SPECIALTY MEDICATIONS)

The medical plan covers prescription drugs provided while you are a patient in a hospital. The plan does not cover:

- Any prescription drug you obtain on an outpatient basis, except as specifically described as covered.
- Any prescription drug obtained illegally outside of the U.S., even if covered when purchased in the U.S.
- Drugs used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.
- Immunizations related to travel or work.
- Injectable drugs, if an oral alternative is available.
- Needles, syringes and other injectable aids, except as covered for diabetic supplies.
- Over-the-counter drugs, biologicals or chemical preparations that can be obtained without a prescription.
- Performance-enhancing steroids.
- Self-injectable drugs.
- Services related to the dispensing, injection or application of a drug.
- Treatment, drug, service or supply to:
 - Stop or reduce smoking or the use of other tobacco products; or
 - Treat or reduce nicotine addiction, dependence or cravings.

This exclusion includes (but is not limited to) counseling, hypnosis, medications, patches and gum.

Specialty Medications

CVS Specialty, a Designated Dispensing Entity, is the preferred specialty pharmacy provider for CVS Health. Select specialty medications are covered only under your prescription drug benefit through CVS Specialty; therefore, such medications are excluded from coverage under this medical plan.

A list of specialty medications that are only covered under the prescription drug plan and must be dispensed by CVS Specialty is available by logging onto www.caremark.com. Since this list is subject to change, you should call (800) 237-2767 for the most current list of such medications. In general, the drugs on this list will not be covered by any pharmacy except for CVS Specialty, regardless

of their medical necessity, their approval, or if the member has a prescription by a physician or other provider. However, in limited circumstances, coverage may be allowed through an alternate provider. Those circumstances include:

- Specialty medications billed by a facility as part of an inpatient hospital stay.*
- Specialty medications billed as part of an emergency room visit.*
- Situations where Medicare is the primary carrier.*
- Limited distribution specialty medications where CVS Caremark does not have access to the drug.*
- Circumstances where homecare is not clinically appropriate (either due to the member's clinical history or due to characteristics of the drug which require special handling) and an alternative infusion site (that is qualified to administer the drug) is not available for coordination of services within a reasonable proximity (30 miles or less).**
- The treating physician has provided written documentation outlining the clinical rationale for the requirement that the member be treated at the designated facility and confirming that the designated facility is unable to accept drug dispensed by CVS Caremark. The written documentation will be reviewed and approved by appropriate CVS Caremark clinical personnel before allowing coverage for the requesting provider under the medical benefit.**

*Prior approval by CVS Caremark is not required.

**Situation will be evaluated by CVS Caremark clinical staff.

Prior authorization may be required for any specialty medication, regardless of whether it is filled through the prescription drug plan or the medical plan. In addition, for designated specialty medications where coverage is still allowed under the medical benefit, the drug, drug dosage(s) and site(s) of care for infusion therapy may require prior authorization for medical necessity, appropriateness of therapy and patient safety.

Infusion Nursing and Site of Care Management for Specialty Medications

Infusion nursing services for select specialty medications that are administered in the home and/or in an ambulatory infusion center are covered through the prescription drug plan and are coordinated through and dispensed by the CVS Caremark Specialty Pharmacy.

For non-oncology infused specialty medications that require administration by a medical professional, a CareTeam nurse will work with you and your provider to assess your clinical history and determine clinically appropriate options (location for your infusion) for clinician-infused specialty medications. Options may include homecare, an ambulatory infusion center, physician office, etc. CareTeam nurses will contact all impacted members to provide assistance and guidance.

WHEN COVERAGE ENDS

Your coverage under the HSP can end for a number of reasons. This section explains how and why your coverage can be terminated, and how you may be able to continue coverage after it ends.

FOR EMPLOYEES

Your HSP coverage ends on the first to occur of the following events:

- your last day of employment with CVS;
- you no longer meet the eligibility requirements for coverage under the plan;
- you retire;
- you decide to discontinue coverage;
- you stop making contributions for coverage; or
- the plan is terminated.

FOR DEPENDENTS

Coverage for your dependents will end on the earliest date any of the following events occurs:

- the date your coverage ends;
- the date dependent coverage under the plan is terminated;
- the date your dependent becomes covered as an employee;
- the date your dependent child turns age 26, except with regard to a disabled child;
- the date you become divorced or legally separated;
- the date your dependent no longer meets the eligibility requirements for coverage under the plan;
- the date you stop making the required contributions for dependent coverage;
- the date you disenroll your dependent as provided under the plan (for example, due to a Change in Status). You may disenroll your dependents who are domestic partners at any time, unless your domestic partner coverage is paid for on a pre-tax basis; or
- the date the plan is terminated.

Note that you are required to provide notice by going to **myHR** at myhr.cvs.com or by calling **myHR** at 1-888-MY-HR-CVS (1-888-694-7287) no later than 30 days following your dependent ceasing to be eligible under the plan.

The plan will provide written notice to you that your coverage has ended if any of the following occur:

- you permit an unauthorized person to use your ID card or you use another person's ID card;
- you knowingly give BCBS IL false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent;

- you commit an act of physical or verbal Use Disorder that imposes a threat to CVS's staff, Blue Cross Blue Shield of Illinois's staff, a Provider or another Covered Person; or
- you violate any terms of the plan.

Note: CVS has the right to demand that you pay back Benefits CVS paid to you, or paid in your name, during the time you were incorrectly covered under the HSP.

RESCISSIONS OF COVERAGE

Fraud and Misrepresentation

The Plan may rescind (*i.e.*, cancel or discontinue on a retroactive basis) coverage if you or your dependents perform an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact. If the rescission relates to medical, prescription or dental coverage, you and/or your dependents (as applicable) will receive at least 30 days advance notice before the coverage is rescinded.

Administrative Delays and Failure to Pay Premiums

Coverage may be retroactively terminated due to administrative delays in processing or due to a failure to timely pay required premiums or contributions toward the cost of coverage. Except where required by law, coverage may be terminated for these reasons without advance notice.

ERRONEOUS CLAIMS AND ADMINISTRATIVE ERRORS

If Blue Cross and Blue Shield of Illinois determines that a benefit was paid under the HSP that either (a) exceeds the covered expenses or (b) was paid in error (for example, if the HSP provided coverage to an ineligible or unverified dependent), you will be required to repay to the Plan the improperly covered benefits. The plan provides that Blue Cross and Blue Shield of Illinois in its discretion may recoup the improperly covered benefits under any methods of collection available, including any of the following:

- notification to you of the error, and an accompanying request that you immediately pay the amount of the improperly covered benefit as directed by Blue Cross and Blue Shield of Illinois;
- offsetting the amount of the improperly covered benefit against any other eligible plan benefits (regardless of the Plan Year in which it is submitted); and
- if permissible under applicable law, withholding the amount of the improperly covered benefits from your pay on an after-tax basis.

If Blue Cross and Blue Shield of Illinois is unable to recover all or a portion of your debt to the plan, you may not be eligible to participate in the plan during the next Annual Enrollment period.

LOSS OF BENEFITS

You or your dependents also may experience a reduction or loss of benefits in any of the following circumstances:

- you fail to follow the plan's procedures;
- you fail to reimburse the HSP for a claim that was paid in error;
- you receive reimbursement for a covered expense by another similar insurance plan which is primary to the HSP while also receiving primary reimbursement from the plan;
- you receive a judgment, settlement or otherwise from any person or entity with respect to the sickness, injury or other condition which gives rise to expenses the plan pays;
- you are found to have committed a fraudulent act against the plan including, but not limited to, the fraudulent filing of a claim for reimbursement;
- the plan is amended or terminated, but only with respect to expenses incurred after the amendment or termination becomes effective; or
- you or your provider fails to file a claim within 12 months of the date service is provided.

CONTINUATION COVERAGE RIGHTS

CONTINUING COVERAGE UNDER COBRA

The plan is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which requires CVS to offer you and your dependents the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage otherwise would end due to the occurrence of a “qualifying event”. Thus, in accordance with COBRA and as described below, if you are no longer eligible to participate in the plan due to a qualifying event, you and your covered spouse and covered dependents will be entitled to continue coverage under COBRA as described below. You may continue only the plan coverage in effect at the time and must pay required premiums. You should call *myHR* or the COBRA Administrator if you have any questions about COBRA.

Qualifying Events and Continuation Periods

The chart below outlines:

- The qualifying events that trigger the right to continue coverage;
- Those eligible to elect continued coverage; and
- The maximum continuation period.

Qualifying Event Causing Loss of Coverage	Covered Persons Eligible for Continued Coverage	Maximum Continuation Period
Termination of active employment (except for gross misconduct)	You Your spouse Your dependent children	18 months
Reduction in work hours	You Your spouse Your dependent children	18 months
Termination of active employment due to military leave (USERRA)	You Your spouse Your dependent children	24 months
Divorce or legal separation or termination of a domestic partnership	You Your spouse Your dependent children	36 months

Qualifying Event Causing Loss of Coverage	Covered Persons Eligible for Continued Coverage	Maximum Continuation Period
Children no longer qualify as eligible for dependent coverage	Your dependent children	36 months
You become entitled to Medicare benefits under the Social Security Act (under Part A, Part B, or both)	You Your spouse Your dependent children	36 months – see discussion below
Your death	You Your spouse Your dependent children	36 months

Medicare Extension for Your Dependents

If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your dependents will last up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for 18 months from the date of your termination of employment or reduction in work hours.

Notice: General

Covered Person's Responsibility

You or your covered dependents must notify **myHR** at 1-888-MY-HR-CVS (1-888-694-7287) to advise them of a divorce, legal separation, or when a covered dependent ceases to be a dependent under the terms of the plan, within 60 days of such event. Failure to do so will result in the loss of the right to elect to continue coverage under this continuation of coverage provision. Notice must be given prior to the qualifying event or as soon as possible thereafter, and not later than 60 days after the qualifying event occurs.

If you or your covered dependents fail to provide **myHR** with timely notice when one of these qualifying events occurs, the right to COBRA coverage will be waived. A covered person who elects COBRA coverage will have the same enrollment rights that apply to active employees.

CVS's Responsibility

For other qualifying events (your end of employment or reduction of hours of employment or your death), CVS will notify the COBRA Administrator. Upon notice of a qualifying event, the COBRA Administrator will notify you and your

covered dependents (individually or jointly) of the right to elect COBRA coverage.

Notice: Disability Extension

If you or one of your covered dependents qualify for disability status under Title II or XVI of the Social Security Act at the time of a reduction in hours or termination of employment, or become disabled within 60 days of beginning COBRA coverage, all covered persons with respect to the disabled individual(s) may extend the continuation coverage an additional 11 months, for up to a total of 29 months.

To extend coverage beyond the 18-month period, you or your covered dependent must notify the COBRA Administrator of the Social Security Administration's ("SSA's) determination within 60 days after the later of:

- the date of the SSA's determination,
- the date on which the qualifying event occurs under the plan, or
- the date on which you or your covered dependent are informed of your responsibility to provide notice of your disability to the COBRA Administrator and of the plan's procedures for providing such notice (which descriptions are included in this Summary), and
- in all cases before the end of the 18-month period of COBRA coverage.

Notice must be provided in writing to the COBRA Administrator and must be sent, along with a copy of the SSA's disability determination, to the COBRA Administrator at the address listed under the GENERAL PLAN INFORMATION section at the end of this Summary.

If there is a determination by the SSA that you or the applicable covered dependent is no longer disabled, the COBRA Administrator must be notified of that fact within 30 days of the SSA's determination. Upon receipt of this notice, COBRA coverage extended beyond the maximum period that would otherwise apply will be terminated on the first day of the month, which is 30 days after the determination that you or your covered dependent is no longer disabled.

Notice: Second Qualifying Events

If you or your covered dependents experience another qualifying event while already on COBRA coverage due to your termination of employment or reduction in hours, your covered dependents may elect to extend the period of COBRA coverage for up to 36 months from the date of termination or reduction in hours, provided notice of the second qualifying event is properly given (as described below).

For example, assume that you and your covered dependents elect COBRA coverage because of your termination of employment. If you die during the first

18 months of COBRA coverage, your covered dependents could elect to continue COBRA coverage for up to 36 months from your date of termination.

A covered person must notify the COBRA Administrator of the second qualifying event within 60 days of the second qualifying event. This notice must be provided in writing to the COBRA Administrator at the address listed at the end of this Summary.

Election

You and your covered dependents are entitled to a period of 60 days in which to elect to continue coverage under the plan. The 60-day election period begins on the date you or your covered dependents would lose plan coverage because of one of the events described above, and ends on the later of 60 days following such date or the date the notice is sent about eligibility to elect to continue coverage.

If you or your covered dependents elect continuation coverage within the 60-day election period, continuation coverage will generally begin on the date regular plan coverage ceases. Even if you or your covered dependents waive continuation coverage, but within the 60-day election period revoke the waiver, continuation coverage will also begin on the date regular plan coverage ceases. A waiver may not be revoked after the end of the 60-day election period.

If you or your covered dependents do not choose continuation coverage within the 60-day election period, eligibility for continuation coverage ends at the end of that period.

Acquiring New Dependents During Continuation

If you acquire any new dependents during a period of continuation (through birth, adoption or marriage), they can be added for the remainder of the continuation period if:

- they meet the definition of an eligible dependent;
- you notify your employer within 30 days of their eligibility (or within 60 days for birth and adoption); and
- you pay the additional required premiums.

Cost of Continuation Coverage

To receive continuation coverage, you or your covered dependents, or any third party, must pay the required monthly premium plus a two percent administrative charge (102%) for the 18 or 36 month continuation period. If you or your covered dependents are eligible for an extension of coverage due to disability, the cost of continuation coverage will be 150% of the normal required monthly premium for all months after the 18th month of continuation coverage.

Each monthly premium for continuation coverage is due on the first day of the month for which coverage is being continued. However, the first such monthly

premium is not due until 45 days after the date on which you and/or your covered dependents initially elect continuation coverage.

Benefits under Continuation Coverage

If you or your covered dependents choose continuation coverage, the coverage is identical to the coverage being provided to similarly situated employees, and their covered dependents who have not experienced a qualifying event. If their coverage changes, continuation coverage will change in the same way.

Payment of Claims

No claim will be payable under this continuation of coverage provision until the applicable premium is paid to the COBRA Administrator.

When COBRA Continuation Coverage Ends

Coverage under this continuation of coverage provision will terminate on the earliest of:

- the date on which CVS ceases to provide a group health plan to any employee;
- the date you or your covered dependents first become covered under any other group health plan after electing continuation coverage, provided that the new plan does not contain any pre-existing condition exclusion that would affect the covered person's coverage under the new plan;
- the date you or your covered dependents become entitled to Medicare benefits under Title XVIII of the Social Security Act after electing continuation coverage;
- you or your dependents die;
- the date the required monthly premium is due, if you or your covered dependents fail to make payment within 30 days after the due date; or
- the end of the applicable maximum COBRA continuation coverage period described above.

Coverage will not be extended beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the continuation coverage period.

Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact(s) identified below. For more information about your rights under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your COBRA Administrator Informed of Address Changes

In order to protect you and your covered dependents rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

COBRA Contact Information

Information regarding your COBRA continuation coverage can be obtained upon request from the COBRA Administrator, as listed below.

Aon Hewitt
P.O. Box 563927
Charlotte, NC 28256

CONTINUING COVERAGE DURING FMLA LEAVE

All eligible participants of this plan who have worked for CVS for at least one year and worked at least 1,250 hours over the previous 12 months are covered under a federal law called the Family and Medical Leave Act (FMLA). According to this law, you are eligible for at least 12 weeks of unpaid leave for the following reasons:

- The birth or adoption of your child or placement of a child with you for adoption or foster care (you must take the leave within one year of the birth, adoption, or placement);
- A serious health condition of your child, spouse, or parent;
- Your own serious health condition that prevents you from performing the duties of your job (this condition must require inpatient care or continuing treatment by a health care provider);
- Any qualifying exigency arising out of the fact that your spouse, child, or parent is a covered member in the Armed Forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation; or.
- For up to a total of 26 work weeks in a single 12-month period to care for a covered member of the Armed forces with a serious injury or illness, but only if you are the child, parent, or next-of-kin (as defined in regulations) with respect to the service member.

If you experience a qualifying FMLA leave event and want to take a leave of absence under FMLA, you should first discuss it with your supervisor as soon as possible. You must then contact the Leave of Absence Department to initiate your leave by logging onto myhr.cvs.com (select the **myLeave** link and follow the prompts) or by calling **myHR** at 1-888-MY-HR-CVS (1-888-694-7287) (and following the prompts to the Leave of Absence Department).

If you take a leave of absence under FMLA, you may continue your coverage under the plan during the leave period by continuing to pay the required contributions.

To the extent any portion of your FMLA leave is paid leave, you will continue to have your benefit contributions deducted from your pay. Otherwise, you must submit your contributions on an after-tax basis. If your required contribution during FMLA leave is more than 30 days late, your coverage will be terminated in accordance with the FMLA retroactive to the date through which you have paid for coverage.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for continued coverage on the same terms as would be applicable to you if you were actively at work, not on an approved FMLA leave.

If you choose not to continue your coverage while on a FMLA leave, you will not be reimbursed for any benefit claims incurred while you are on the FMLA leave. To reinstate your coverage upon a return from a leave of absence, you must do so within 30 days of returning from your leave, by either calling **myHR** at 1-888-MY-HR-CVS (1-888-694-7287) or going to **myhr.cvs.com**. If you do not call **myHR** or visit **myhr.cvs.com** and follow the necessary steps for reenrollment, you will be required to wait until the Annual Enrollment period to reinstate your coverage. Reinstatement of coverage is not automatic.

If you do not return to work after your FMLA leave ends, you may be allowed to continue your coverage at the active-employee rate under another CVS leave policy (provided premiums are paid). Otherwise, your coverage at the active-employee rate will terminate (although as described below you and your dependents may have COBRA continuation coverage rights).

If your medical coverage ends because your approved FMLA leave is considered terminated by CVS, you and your dependents may, on the date of such termination, be eligible to elect to continue your coverage under COBRA. COBRA continuation coverage will be available on the same terms as though your employment terminated, for reasons other than for gross misconduct, on such date.

State Family and Medical Leave Laws

CVS' FMLA policy complies with any state law that provides greater family or medical leave rights than those provided under this FMLA policy. If your leave qualifies under the FMLA and under a state law, you will receive the greater benefit.

If CVS Changes Benefits

If CVS offers new benefits or changes its benefits while you are on an FMLA leave, you are eligible for the new or changed benefits, but your contributions for these benefits may increase.

CONTINUING COVERAGE DURING LEAVES OF ABSENCES (OTHER THAN FMLA OR USERRA)

Company-Approved Leaves

If you are on a CVS-approved leave of absence (other than a personal leave or military leave of absence), it is CVS's policy to allow you and your dependents to continue your health coverage under the plan for up to 180 days at the active-employee rate, provided you continue to pay plan premiums to CVS, unless your collective bargaining agreement indicates otherwise. If you continue to be on a company-approved leave of absence at the end of the foregoing 180-day period, you may be eligible to elect to continue your health coverage under COBRA. COBRA continuation coverage will be available on the same terms as though your employment terminated, for reasons other than for gross misconduct. As discussed in detail in this Summary above, under COBRA you must pay the full cost of the benefits plus a 2% administrative charge.

Personal Leaves

If you are on a personal leave of absence, it is CVS's policy to allow you and your dependents to continue your health coverage under the plan for up to 30 days at the active-employee rate, provided you continue to pay plan premiums to CVS. If you continue to be on a leave of absence at the end of the foregoing 30-day period, you may be eligible to elect to continue your coverage under COBRA. COBRA continuation coverage will be available on the same terms as though your employment terminated (for reasons other than gross misconduct). As discussed in detail in this Summary, under COBRA you must pay the full cost of the benefits plus a 2% administrative charge.

Return from Leave

If you choose not to continue your coverage while on a CVS-approved leave of absence (including a personal leave), you may reinstate your coverage when you return to work. Reinstatement of coverage is *not* automatic. When you return to work, call *myHR* at 1-888-MY-HR-CVS (1-888-694-7287) or visit myhr.cvs.com within 30 days of returning from your FMLA leave to reenroll in the plan. If you do not call *myHR* or visit myhr.cvs.com and follow the necessary steps for reenrollment within the first 30 days of returning to work, you will be required to wait until the Annual Enrollment period to reinstate your coverage.

CONTINUATION COVERAGE UNDER USERRA

Under a federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), you have certain rights regarding continuance of benefits while you are on a leave of absence for military service or uniformed service (referred to herein as a “military leave of absence”). The terms “uniformed services” or “military service” mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency. A “leave of absence” is a predetermined period of time in which you are not working for CVS. You are, however, expected to return to active employment at the end of your leave of absence.

It is CVS’s policy to allow employees on a military leave of absence to continue health coverage under the plan for up to 12 months at the active-employee cost. If you continue to be on a military leave of absence at the time the foregoing 12-month period is exhausted, under USERRA, you may elect to continue coverage for an additional 24 months (or if less, for the period you are on military leave) by paying for the full cost of the benefits plus a 2% administrative charge. Under USERRA, covered dependents also have a right to continue their health coverage during the employee’s period of military leave of absence.

Regardless of whether you choose to continue health coverage while on a military leave of absence, if you return to a position of employment with CVS, your health coverage and that of your eligible dependents will be reinstated, provided you call **myHR** at 1-888-MY-HR-CVS (1-888-694-7287) or go to myhr.cvs.com within 30 days of your return to work. If you do not call **myHR** or go to myhr.cvs.com and follow the necessary steps for reenrollment, you will be required to wait until the Annual Enrollment period to reinstate your coverage. Reinstatement of coverage is *not* automatic. No exclusions or waiting period may be imposed on you or your eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

For more information about filing for coverage while you are on a military leave of absence, and applicable costs, call **myHR** at 1-888-MY-HR-CVS (1-888-694-7287).

COORDINATION OF BENEFITS

EFFECT OF ANOTHER PLAN ON THIS PLAN'S BENEFITS

If you have coverage under other group plans or receive payments for an illness or injury caused by another person, the benefits you receive from this plan may be adjusted. This may reduce the benefits you receive from the HSP. The adjustment is known as coordination of benefits (COB).

Benefits available through other group plans and/or no-fault automobile coverage are coordinated with the HSP. "Other group plans" include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, regardless of whether that plan is insured.
- "No-fault" and traditional "fault" auto insurance, including medical payment coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under the HSP will be reduced, Blue Cross and Blue Shield of Illinois must first use the rules listed below, in the order shown, to determine which plan is primary (pays its benefits first). The first rule that applies in the chart below will determine which plan pays first:

If . . .	Then . . .
1. One plan has a COB provision and the other plan does not	The plan without a COB provision determines its benefits and pays first.
2. One plan covers you as a dependent and the other covers you as an employee or retiree	The plan that covers you as an employee or retiree determines its benefits and pays first.
3. You are eligible for Medicare and not actively working	<p>The HSP will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the HSP pays Benefits first and Medicare pays benefits second:</p> <ul style="list-style-type: none">• Employees with active current employment status age 65 or older and their Spouses age 65 or older; and• Individuals with end-stage renal disease, for a limited period of time.

If . . .	Then . . .
<p>4. A child’s parents are married or living together (whether or not married)</p>	<p>The plan of the parent whose birthday occurs earlier in the calendar year determines its benefits and pays first. If both parents have the same birthday, the plan that has covered the parent the longest determines its benefits and pays first. But if the other plan does not have this “parent birthday” rule, the other plan’s COB rule applies.</p>
<p>5. A child’s parents are separated or divorced with joint custody, and a court decree does not assign responsibility for the child’s health expenses to either parent, or states that both parents are responsible for the child’s health coverage</p>	<p>The “birthday rule” described above applies.</p>
<p>6. A child’s parents are separated or divorced, and a court decree assigns responsibility for the child’s health expenses to one parent</p>	<p>The plan covering the child as the assigned parent’s dependent determines its benefits and pays first.</p>
<p>7. A child’s parents are separated, divorced or not living together (whether or not they have ever been married) and there is no court decree assigning responsibility for the child’s health expenses to either parent</p>	<p>Benefits are determined and paid in this order:</p> <ul style="list-style-type: none"> a) The plan of the custodial parent pays, then b) The plan of the spouse of the custodial parent pays, then c) The plan of the non-custodial parent pays, then d) The plan of the spouse of the non-custodial parent pays.
<p>8. You have coverage:</p> <ul style="list-style-type: none"> • as an active employee (that is, not as a retired or laid-off employee) and also have coverage as a retired or laid-off employee; or • as the dependent of an active employee and also have 	<p>The plan that covers you as an active employee or as the dependent of an active employee determines its benefits and pays first.</p> <p>This rule is ignored if the other plan does not contain the same rule.</p>

If . . .	Then . . .
coverage as the dependent of a retired or laid-off employee	Note: this rule does not apply if rule 2 (above) has already determined the order of payment.
9. You are covered under a federal or state right of continuation law (such as COBRA)	<p>The plan other than the one that covers you under a right of continuation law will determine its benefits and pay first.</p> <p>This rule is ignored if the other plan does not contain the same rule.</p> <p>Note: this rule does not apply if rule 2 (above) has already determined the order of payment.</p>
10. The above rules do not establish an order of payment	The plan that has covered you for the longest time will determine its benefits and pay first.

When the other plan pays first, the benefits paid under the HSP are reduced as shown here:

- The amount the HSP would pay if it were the only coverage in place, *minus*
- Benefits paid by the other plan(s).

This prevents the sum of your benefits from being more than you would receive from just the HSP.

If your other plan(s) pays benefits in the form of services rather than cash payments, the HSP uses the cash value of those services in the calculation.

The HSP always pays secondary to any medical payment, personal injury protection, or no-fault coverage under any automobile policy that is available to you. You should review your automobile policy to ensure that uncoordinated medical benefits have been chosen so that the auto insurance policy is the primary payer.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that BCBS of Illinois should have paid. If this occurs, the HSP may pay the other plan the amount owed, or the provider of service who received the overpayment will refund the plan which overpaid.

If the HSP pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored

benefit plans, including this plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the HSP overpays a health care Provider, Blue Cross and Blue Shield of Illinois reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If the HSP pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment the HSP made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount the plan paid in excess of the amount that should have paid under the HSP. If the refund is due from another person or organization, the Covered Person agrees to help the plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the plan may reduce the amount of any future benefits for the covered person that are payable under the HSP. The reductions will equal the amount of the required refund. CVS may have other rights in addition to the right to reduce future benefits.

CLAIM FILING AND APPEALS PROCEDURES

The plan has procedures for submitting claims, making decisions on claims and filing an appeal when you don't agree with a claim decision. You and Blue Cross and Blue Shield of Illinois must meet certain deadlines that are assigned to each step of the process, depending on the type of claim.

TYPES OF CLAIMS

To understand the claim and appeal process, you need to understand how claims are defined:

- ***Urgent care claim:*** A claim for medical care or treatment where delay could seriously jeopardize your life or health or your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the requested care or treatment.
- ***Pre-service claim:*** A claim for a benefit that requires Blue Cross and Blue Shield of Illinois's approval of the benefit in advance of obtaining medical care (precertification).
- ***Concurrent care claim extension:*** A request to extend a course of treatment that was previously approved.
- ***Concurrent care claim reduction or termination:*** A decision to reduce or terminate a course of treatment that was previously approved.
- ***Post-service claim:*** A claim for a benefit that is not a pre-service claim and for which the service has been rendered and billed.

KEEPING RECORDS OF EXPENSES

It is important to keep records of medical expenses for yourself and your covered dependents. You will need these records when you file a claim for benefits. Be sure you have this information for your medical records:

- Name and address of physicians;
- Dates on which each expense was incurred; and
- Copies of all bills and receipts.

FILING CLAIMS

If you use an out-of-network provider, you must file a claim to be reimbursed for covered expenses. You can obtain a claim form from Blue Cross and Blue Shield of Illinois Member Services by calling the number on the back of your ID card, or by going online at www.bcbsil.com/cvs. The form has instructions on how, when and where to file a claim.

File your claims promptly – ***the filing deadline is 12 months after the date you incur a covered expense.*** If, through no fault of your own, you are unable to meet

that deadline, your claim will be accepted if you file it as soon as possible. Claims filed more than two years after the deadline will be accepted only if you had been legally incapacitated.

You may file claims and appeals yourself or through an “authorized representative,” who is someone you authorize in writing to act on your behalf. In a case involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. The plan will also recognize a court order giving a person authority to submit claims on your behalf.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Blue Cross and Blue Shield of Illinois within the timeframes specified below. The notice will explain the reason for the denial and the review procedures.

TIME FRAMES FOR CLAIM PROCESSING

Blue Cross and Blue Shield of Illinois will make a decision on your claim for appeal.

- If Blue Cross and Blue Shield of Illinois *approves* the claim, they will send you an Explanation of Benefits (EOB) that shows you how they determined the benefit payment.

Keep in Mind

You can receive your EOBs via U.S. Mail or electronically on your secure member web site. If you'd like to receive electronic EOBs, log on to Blue Access for Members (BAM) at www.bcbsil.com/cvs, and follow the instructions.

- If Blue Cross and Blue Shield of Illinois *denies* your claim, they must give you a written notice of the denial.

The following chart shows when Blue Cross and Blue Shield of Illinois must notify you that your claim has been denied.

Type of Claim	Blue Cross and Blue Shield of Illinois Must Notify You
Urgent care claim	As soon as possible, but not later than 72 hours The determination may be provided in writing, electronically or orally. If the determination has been provided orally, a written or electronic notification will be sent no later than 3 calendar days after the oral notification.
Pre-service claim	15 calendar days
Concurrent care claim extension	Urgent care claim – as soon as possible, but not later than 72 hours, provided the request was received at least 24 hours before the end of the approved treatment Other claims – 15 calendar days
Concurrent care claim reduction or termination	With enough advance notice to allow you to appeal
Post-service claim	30 calendar days

Extensions of Time Frames

The time periods described in the chart may be extended, as follows:

- *For urgent care claims:* If Blue Cross and Blue Shield of Illinois does not have enough information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Blue Cross and Blue Shield of Illinois receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after you provide the additional information.
- *For non-urgent pre-service and post-service claims:* The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Blue Cross and Blue Shield of Illinois will notify you of the extension before the original notification time period has ended.

If an extension of time is needed because Blue Cross and Blue Shield of Illinois needs more information to process your post-service claim:

- Blue Cross and Blue Shield of Illinois will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information.
- Blue Cross and Blue Shield of Illinois will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Blue Cross and Blue Shield of Illinois receives the information, if earlier).

If you do not provide the information, your claim will be denied.

NOTICE OF CLAIM DENIAL

A claim denial is also called an adverse benefit determination. An adverse benefit determination is a decision Blue Cross and Blue Shield of Illinois makes that results in denial, reduction or termination of:

- A benefit; or
- The amount paid for a service or supply.

It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the plan; or
- Blue Cross and Blue Shield of Illinois determines that a benefit or service is not covered by the plan because:
 - It is not included in the list of covered benefits;
 - It is specifically excluded;
 - It is not medically necessary; or
 - A plan limit or maximum has been reached.

If your claim is denied, in whole or in part, Blue Cross and Blue Shield of Illinois will send you written notice of an adverse benefit determination. The notice will give you:

- The reason or reasons that your claim was denied.
- A reference to the specific plan provisions on which the denial was based.
 - If an internal rule, guideline, protocol or other similar criterion was relied upon to determine a claim, you'll either receive:
 - A copy of the actual rule, guideline, protocol or other criterion; or
 - A statement that the rule, guideline, protocol or other criterion was used and that you can request a copy free of charge.

- If the denial is based on a plan provision such as medical necessity, experimental treatment, or a similar exclusion or limit, you'll either receive:
 - An explanation of the scientific or clinical judgment for the determination; or
 - A statement that you can receive the explanation free of charge upon request.
- Information sufficient to identify your claim.
- A description of any additional material or information needed to perfect the claim and the reason why the material or information is necessary.
- An explanation of the plan's claim review and appeal procedures, applicable time limits and a statement of your rights to bring a civil action under ERISA section 502(a) after completing all required levels of appeal.
- An explanation of the expedited claim review process for an urgent care claim. In the case of an urgent care claim, the plan may notify you by phone or fax, then follow up with a written or electronic notice within three days after the notification.

APPEALING A MEDICAL CLAIM DECISION

If you disagree with a claim determination, you may file an appeal, following the appeal process outlined below.

Three Steps in the Appeal Process

The plan provides for two levels of appeal to Blue Cross and Blue Shield of Illinois, plus an option to seek external review:

- You must request your first appeal (level one) within 180 calendar days after you receive the notice of a claim denial.
- If you are dissatisfied with the outcome of your level one appeal to Blue Cross and Blue Shield of Illinois, you may ask for a second review (a level two appeal). You must request a level two appeal no later than 60 days after you receive the level one notice of denial.
- After you have exhausted the level one and level two appeal process, you may file a voluntary appeal for external review if your claim meets certain requirements. You must submit a request for external review within four (4) months of the date you receive a final denial notice.

How to Appeal a Claim Denial

Your level one and level two appeals may be submitted in writing or by making a phone call to Blue Cross and Blue Shield of Illinois Member Services. Your appeal should include:

- Patient’s name;
- Your employer’s name;
- A copy of Blue Cross and Blue Shield of Illinois’s notice of the adverse benefit determination;
- Your reasons for making the appeal; and
- Any other documentation or written information to support your request that you would like to have considered.

Send your appeal to Blue Cross and Blue Shield of Illinois Member Services at the address shown on your ID card, or call Member Services at the toll-free telephone number shown on your ID card.

Based on the type of claim, Blue Cross and Blue Shield of Illinois must respond to your appeal within the time frames shown in the following chart:

Type of Claim	Level One Appeal	Level Two Appeal
Urgent care claim	72 hours	72 hours
Pre-service claim	15 calendar days	15 calendar days
Concurrent care claim extension	Treated like an urgent care claim or a pre-service claim, depending on the circumstances	Treated like an urgent care claim or a pre-service claim, depending on the circumstances
Post-service claim	30 calendar days	30 calendar days

If requested, you will be given reasonable access to, and copies of, all documents, records, or other information relevant to your claim, free of charge, and the identity of any medical expert consulted in connection with your initial claim (regardless of whether the expert’s advice was used to deny your claim).

Upon receipt of your appeal, Blue Cross and Blue Shield of Illinois will make a full and fair review of your claim, taking into account all comments, documents, records, and other information submitted by you (regardless of whether the information was submitted or considered in determining your initial claim). The review will not defer to Blue Cross and Blue Shield of Illinois’s prior decision. If Blue Cross and Blue Shield of Illinois’s claim denial was based on medical judgment, Blue Cross and Blue Shield of Illinois will consult with a medical

professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with its prior decision nor a subordinate of any such person. Before Blue Cross and Blue Shield of Illinois makes its appeal determination, if applicable, you will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by Blue Cross and Blue Shield of Illinois (or at the direction of Blue Cross and Blue Shield of Illinois) or any or additional rationale as soon as possible and in sufficient time to allow you the opportunity to respond before Blue Cross and Blue Shield of Illinois issues its appeal determination.

The review will be performed by plan personnel who were not involved in making the adverse benefit determination.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Blue Cross and Blue Shield of Illinois. In the cast of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

If your appeal is approved, Blue Cross and Blue Shield of Illinois will notify you in writing. If your appeal is denied, in whole or in part, the written notice will explain:

- The specific reason(s) for the adverse benefit determination.
- References to the specific plan provisions on which the adverse benefit determination was based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- Information sufficient to identify your claim.
- Any internal procedures or clinical information upon which the adverse benefit determination was based (or a statement that this information will be provided free of charge, upon request).
- If the adverse benefit determination is based on a medical necessity, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to your medical circumstances (or a statement that this explanation will be provided free of charge, upon request).
- The plan's available review procedures, including information about the plan's external review procedures. The notice will also state that you have the right to bring a civil action under Section 502(a) of ERISA after your claims and appeals process is exhausted.

If the Level One and Level Two appeals uphold the original adverse benefit determination for a *medical* claim, you may have the right to pursue an external review of your claim. See [External Review](#) for details.

Exhaustion of Internal Appeals Process

Generally, you must complete all the plan's appeal levels before asking for an external review or bringing an action in litigation. However, if Blue Cross and Blue Shield of Illinois (or the plan or its designee) does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the plan's appeal requirements. This is known as deemed exhaustion. When this occurs, you may proceed with external review or pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

Exception

There is an exception to the deemed exhaustion rule. You cannot submit your claim or internal appeal directly to external review if the rule violation was:

- Minor and not likely to influence a decision or harm you; and
- For a good cause or was beyond Blue Cross Blue Shield of Illinois's or the plan's (or its designee's) control; and
- Part of an ongoing good faith exchange between you and Blue Cross and Blue Shield of Illinois or the plan; and
- Not part of a pattern of practice of violations by Blue Cross Blue Shield of Illinois or the plan.

If the claims procedures have not been strictly adhered to, you have the right to request a written explanation of the violation from Blue Cross and Blue Shield of Illinois or the plan. Within 10 days after receiving your request, Blue Cross and Blue Shield of Illinois or the plan will give you an explanation of the basis, if any, for asserting that the violation should not cause the internal claim and appeal process to be deemed exhausted. If an external reviewer or court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit your claim and pursue the internal appeal of the claim.

External Review

You may file a voluntary appeal for external review of any final appeal determination that qualifies. An external review is a review of an adverse benefit determination by an independent external review (IRO).

If you file for a voluntary external review, any applicable statute of limitations will be tolled (suspended) while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

Keep in Mind

You do not have to file for voluntary review. After you exhaust the plan's two standard levels of appeal, you may pursue any available remedies under Section 502(a) of ERISA. Your decision to decline the voluntary review process is not considered a failure to exhaust your administrative remedies.

Claims That Qualify for External Review

You may request an external review of a rescission (coverage that was cancelled or discontinued retroactively) or a claim denial based on medical judgment if:

- You have exhausted the plan's appeal process; or
- Blue Cross and Blue Shield of Illinois (or the plan or its designee) has not strictly followed all claim determination and appeal requirements under federal law (except for minor violations).

A denial based upon your eligibility does not qualify for external review.

You must complete all of the levels of standard appeal before you can request an external review, except in a case of deemed exhaustion (see [Exhaustion of the Internal Appeals Process](#) above for an explanation of deemed exhaustion). Your authorized representative may act on your behalf in filing and pursuing this voluntary appeal, subject to any plan verification procedures.

Deadline for Requesting an External Review

You must submit a request for external review within four (4) months of the date you receive a final denial notice. 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. You also must include a copy of the notice and all other pertinent information that supports your request.

Any request for external review must be made in writing, except in the case of an urgent care medical claim, which can also be made orally.

Preliminary Review

Blue Cross and Blue Shield of Illinois will do a preliminary review of your request for an external review within five (5) business days of receiving the request. The preliminary review determines whether:

- You were covered under the plan at the time the service was requested or provided;
- The adverse determination does not relate to eligibility;
- You have exhausted the internal appeals process (unless deemed exhaustion applies); and
- You have provided all paperwork necessary to complete the external review.

Blue Cross and Blue Shield of Illinois must notify you in writing of the results of the preliminary review within one (1) business day after completing the review.

- If your request is complete but not eligible for external review, Blue Cross and Blue Shield of Illinois's notice will include the reasons why it is not eligible and provide contact information for the Employee Benefits Security Administration (toll-free number **1-866-444-3272**).
- If the request is not complete, Blue Cross and Blue Shield of Illinois's notice will describe the information or materials needed to make the request complete. Blue Cross and Blue Shield of Illinois will allow you to perfect the request for external review within the four months filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to IRO

If your request for external review is approved, Blue Cross and Blue Shield of Illinois will assign an accredited IRO to conduct the review. The IRO will notify you in writing that your request is eligible and accepted for review, and give you an opportunity to submit additional information within 10 business days for a non-emergency (standard) external review.

A neutral, independent clinical reviewer, with appropriate expertise in the area in question, will review your material. The decision of the external reviewer is binding unless otherwise allowed by law.

The IRO will review all of the information and documents received within required time frames. In reaching a decision, the assigned IRO will not be bound by any decisions or conclusions reached during the plan's claims and appeals process. The IRO will consider the following in reaching a decision, as appropriate:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the plan or issuer, you or your treating provider;
- 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;
- 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;
- Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield of Illinois, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

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

The assigned IRO must provide written notice of the final decision within 45 days after receiving the request for external review. The IRO must deliver the final decision to you, Blue Cross and Blue Shield of Illinois and the plan.

The IRO's notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (e.g., the date or dates of service, the health care provider, the claim amount, the diagnosis code and its meaning, the treatment code and its meaning, and the reasons for the previous denials).
- The date the IRO received the external review assignment from Blue Cross and Blue Shield of Illinois and the date of the IRO's decision.
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards that the IRO considered in making its determination.
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision.
- A statement that the determination is binding, except to the extent that other remedies may be available under state or federal law to either the plan or you.
- A statement that you may still be eligible to seek judicial review of any adverse external review determination.
- Current contact information, including the telephone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist you.

If the IRO's Final External Review Decision reverses Blue Cross and Blue Shield of Illinois's adverse benefit determination, the plan will accept the decision and provide the benefits for the service or procedure in accordance with the terms and conditions of the plan. If the IRO's decision confirms Blue Cross and Blue Shield of Illinois's adverse benefit determination, the plan will not be obligated to provide benefits for the service or procedure.

Expedited External Review

The plan must allow you to request an expedited external review at the time:

- You receive an adverse benefit determination, if:
 - That determination involves a medical condition for which the timeframe for completing an expedited internal appeal (the standard level one and level two appeal process) 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
- You exhaust the internal appeal process (level one and level two), if:
 - You have a medical condition where the timeframe for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
 - It 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.

As soon as Blue Cross and Blue Shield of Illinois receives your request for an expedited external review, Blue Cross and Blue Shield of Illinois will determine whether the request meets the reviewability requirements for standard external review and immediately notify you of its determination.

If your request for an expedited external review is approved, Blue Cross and Blue Shield of Illinois will assign an IRO. And forward your request to the IRO (electronically, by telephone or fax, or by other similar manner) along with all documents and information it considered in making its adverse benefit determination.

The IRO will follow the review process described above and make a decision as quickly as your medical condition or circumstances require, and within 72 hours after the IRO receives your request for the expedited review. If the IRO gives you its decision orally, the IRO must follow up with written confirmation to you, Blue Cross and Blue Shield of Illinois and the plan within 48 hours of making the decision.

LEGAL ACTION

If you believe your Claim under the plan is being improperly denied in whole or in part, you have the right to bring a legal action. However, no legal action can be brought until you have exhausted all the steps in the appeal process provided in the plan. You must bring any such legal action within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action.

SUBROGATION AND RIGHT OF REIMBURSEMENT

The provisions of this section apply to anyone on whose behalf the plan pays or has paid benefits (“you” or “your”), including all current and former plan participants, as well as, for purposes of the obligations under this section, all persons acting on behalf of an individual who receives or has received benefits under the plan, such as the parents, guardians or other representatives of a dependent child or the personal representatives of an individual’s estate, decedents, minors and incompetent or disabled persons. No adult may assign any rights that he or she may have to any minor child(ren) without the prior written informed and express consent of the plan.

The plan’s right of subrogation, reimbursement, and recovery, as set forth below, extends to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims, including (but not limited to):

- Liability coverage;
- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Medical payments coverage;
- Workers’ compensation coverage;
- No fault automobile coverage; or
- Any first party insurance coverage.

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan’s subrogation and reimbursement interests are fully satisfied.

SUBROGATION

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the plan. The plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation

claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

REIMBURSEMENT

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

WHEN YOU ACCEPT PLAN BENEFITS

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree to the following rules:

- ***Constructive trust:*** If you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the plan's subrogation and reimbursement interest are fully satisfied.
- ***Lien rights:*** The plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan, including (but not limited to) you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.
- ***Assignment:*** In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.
- ***First-priority claim:*** By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

- **Cooperation:** You agree to cooperate fully with the plan’s efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative, including (but not limited to) completing and submitting:
 - Any applications or other forms or statements as the plan may reasonably request; and
 - All documents related to or filed in personal injury litigation.

Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan’s subrogation or recovery interest or prejudice the plan’s ability to enforce the terms of this plan provision. This includes (but is not limited to) refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the plan’s subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act (“HIPAA”), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

- **Jurisdiction:** By accepting benefits from the plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever

rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

APPLICABILITY TO ALL SETTLEMENTS AND JUDGMENTS

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

INTERPRETATION

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

RIGHT OF RECOVERY

The plan also has the right to recover benefits it has paid on the beneficiary's behalf that are:

- Made in error;
- Made due to a mistake in fact;
- Advanced during the time period in which the beneficiary is required to meet and has not yet met the plan year Deductible under the plan; or
- Advanced during the time period in which the beneficiary is required to meet and has not yet met the Out-of-Pocket Maximum for the plan year.

Benefits paid because the beneficiary misrepresents facts are also subject to recovery by the plan.

If the plan provides the beneficiary a benefit that exceeds the amount that should have been paid, the plan will:

- Require that the overpayment be immediately returned when requested,
or

- Reduce a future benefit payment for the beneficiary or his or her Dependents by the amount of the overpayment.

In addition, if the plan makes payments with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the terms of the plan, the plan shall have the right, exercisable in its sole discretion, to recover such excess payments.

YOUR PRIVACY RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

We understand that your health information is private, and we are committed to maintaining the privacy of your medical information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you certain rights to privacy concerning your health information. The Plan will follow the policies below to help ensure that your health information (or “protected health information” (“PHI”)) is protected and remains private.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care provider who is paid by the Plan, a record is created. The record may contain your PHI. In general, the Plan will only use or disclose your PHI without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure.

The Plan does not operate by itself; it is operated and administered by CVS and the Insurance Companies acting on the Plan’s behalf. As a result, PHI used or disclosed by the plan (as discussed below) necessarily means that CVS and the Insurance Companies, as applicable are using or disclosing the PHI on behalf of the plan. As a result, references to the plan in this section shall also be construed as references to CVS and the Insurance Companies to the extent necessary to carry out the actions of the plan.

PERMITTED USES AND DISCLOSURES

The following categories describe different ways that the plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the plan is permitted to use and disclose information will fall within one of the categories.

The plan may use or disclose your PHI for the following reasons:

- for treatment, payment, and health care operations (including disclosures to the plan’s Business Associates to carry out these functions);
- to family members, relatives, and close personal friends involved in your care or payment for your care (but only to the extent of their involvement);
- as required by law;
- to avert a serious threat to your health and safety or the health and safety of the public or another person;
- for purposes of organ or tissue donation;
- as required by military command authorities, if you are a member of the armed forces;
- for workers’ compensation or similar programs;

- for public health activities (for example, to prevent or control disease, injury, or disability, to report reactions to medications or problems with products, etc.);
- for certain health oversight activities (for example, audit and inspection to monitor the health care system);
- in response to a court or administrative order or subpoena or discovery request;
- to the Department of Health and Human Services for purposes of determining the plan's compliance with these privacy rules;
- to coroners, medical examiners, and funeral directors (for example, to identify a deceased person or determine the cause of death);
- for national security and intelligence activities; and
- if you are an inmate of a correctional institution for specified reasons such as the protection of your health and safety.

DISCLOSURES TO CVS

The Plan will disclose your PHI to CVS for Plan administration purposes only upon receipt of a certification from CVS that the Plan sets forth the permitted uses and disclosures of PHI by CVS on behalf of the Plan, and that CVS has agreed to the following assurances:

- CVS shall implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the plan;
- CVS shall not further use or disclose your PHI other than as permitted or required by the plan documents or as required by law;
- CVS shall ensure that any agents, including subcontractors, to whom it provides PHI received from the plan agree to the same restrictions and conditions that apply to CVS with respect to such information and agree to implement reasonable and appropriate security measures to protect such information;
- CVS shall not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of CVS;
- CVS shall report to the plan any use or disclosure of PHI that is inconsistent with the permitted uses and disclosures, including any security incidents, of which it becomes aware;
- CVS shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the plan available to the Department of Health and Human Services for purposes of determining whether the plan is complying with applicable regulations;
- CVS shall, if feasible, return or destroy all PHI received from the plan about you and retain no copies of the information when it is no longer needed for the purpose for which disclosure was made, except that, if such

return or destruction is not feasible, to limit further uses or disclosures to those purposes that make such return or destruction infeasible;

- CVS shall ensure that there is adequate separation between the plan and CVS (as described below) and that the separation is supported by reasonable and appropriate security measures;
- CVS shall make your PHI available to you (as described below);
- CVS shall make your PHI available to you for amendment and incorporate any amendment into your PHI (as described below); and
- CVS shall make available the information required to provide you an accounting of disclosures (as described below).

ACCESS TO PHI

The plan will make your PHI available to you for inspection and copying upon your written request to the applicable Insurance Company. The plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

AMENDMENT OF MEDICAL INFORMATION

If you feel that PHI the plan has about you is incorrect or incomplete, you may ask the plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the plan. Your request must be made in writing and submitted to the applicable Insurance Company. In addition, you must provide a reason that supports your request.

The applicable Insurance Company may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the applicable Insurance Company may deny your request if you ask the Insurance Company to amend information that:

- is not part of the medical information kept by or for the plan;
- was not created by the plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

ACCOUNTING OF DISCLOSURES

If you wish to know to whom your PHI has been disclosed for any purpose other than (a) treatment, payment, or health care operations, (b) pursuant to your written authorization, and (c) for certain other purposes, you may make a written request to the applicable Insurance Company. Your request must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request

within a 12-month period will be free. The accounting will not include disclosure for the purposes of treatment, payment, or health care operations. In addition, the accounting will not include disclosures that you have authorized in writing.

SEPARATION BETWEEN THE PLAN AND CVS

Only employees of CVS who are involved in the day-to-day operation and administrative functions of the plan will have access to your medical information. In general, this will only include the following individuals: employees of the Human Resources Department and the Legal and Employee Relations Departments. These individuals will receive appropriate training regarding the plan's privacy policies. In the event an individual fails to comply with the plan's provisions regarding the protection of your medical information, CVS will take appropriate action in accordance with its established policy for failure to comply with the plan's privacy provisions.

OTHER USES OF PHI

Any other uses and disclosures of your PHI will be made only with your written authorization. If you provide the plan authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the plan will no longer use or disclose your PHI for the reasons covered by your written authorization. Please note that the plan is unable to take back any disclosures it has already made with your authorization.

If you have a question about your rights under the HIPAA regulations, call **myHR** at 1-888-MY-HR-CVS (1-888-694-7287).

ELECTRONIC DATA SECURITY STANDARDS

The plan will apply the following provisions to enable it to use and disclose electronic PHI as necessary to comply with the requirements of the HIPAA "Security Standards" promulgated under the Health Insurance Portability and Accountability Act of 1996 (the "Security Regulation") relating to the use and disclosure of PHI that is maintained in an electronic format ("Electronic PHI").

- CVS will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the plan.
- CVS will ensure that the separation requirements applicable to the plan described above are supported by reasonable and appropriate data security measures to limit access to Electronic PHI to authorized users.
- CVS will ensure that any agent, including a subcontractor, to whom it provides Electronic PHI, agrees to implement reasonable and appropriate security measures to protect the information.

- CVS will report to the plan any security incident (within the meaning of 45 C.F.R. § 164.304) of which it becomes aware.
- The plan and CVS will take any such further action as is required to comply with the Security Regulation.

DATA BREACH REPORTING

As provided by Title XIII of the American Recovery and Reinvestment Act of 2009 and the related final regulations issued by the Department of Health and Human Services (“Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules” as set forth in Parts 160 and 164 of Title 45 of the Code of Federal Regulations), the plan and/or its vendors will provide notice of any “breach” of security involving unsecured PHI to the affected individuals and to the Department of Health and Human Services, as applicable.

If you have a question about your rights under the HIPAA regulations, call **myHR** at 1-888-MY-HR-CVS (1-888-694-7287).

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

YOUR RIGHTS UNDER ERISA

As a participant in the CVS Health Welfare Benefit Plan (the “Plan”), under which the HSP is a component benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites and union halls, all documents governing the HSP, including insurance contracts and collective bargaining agreements and a copy of the latest annual report for the Plan (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the HSP, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the HSP because of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
 - you lose coverage under the plan,
 - you become entitled to elect COBRA continuation coverage, or

- your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the plan. The people who operate your HSP, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including CVS, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents (which would include the Welfare Benefit Plan document) or the latest annual report from a plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court subsequent to exhausting the plan’s claims procedures. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court subsequent to exhausting the plan’s claims procedures. If it should happen that plan’s fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Department of Labor's Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800) 998-7542.

ADMINISTRATIVE INFORMATION

This section provides information about the administration of the Health Savings Plan (HSP) described in this SPD, as well as information required of all Summary Plan Descriptions by the Employee Retirement Income Security Act of 1974 (ERISA). While you may not need this information for your day-to-day participation, it is information you may find important.

The Plan's benefits are administered by the Plan Administrator. BCBSIL is the Claims Administrator and processes claims for the HSP and provides appeal services; however, BCBSIL and CVS are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Participating or Non-Participating Provider. BCBSIL and CVS are neither liable nor responsible for the treatment, services or supplies provided by the Participating or Non-Participating Providers.

PLAN INFORMATION

Formal Plan Name

The HSP is a component plan under the CVS Health Welfare Benefit Plan.

Plan Number

The plan number for the CVS Health Welfare Benefit Plan, under which the HSP is a component plan, is 510.

Employer Identification Number

The Employer Identification Number (EIN) assigned to CVS Pharmacy, Inc. by the Internal Revenue Service (IRS) is 05-0340626.

Plan Year

The plan records are kept on a 12-month period beginning June 1 and ending May 31.

Type of Plan

The HSP is a component plan under the CVS Health Welfare Benefit Plan.

Type of Administration

The plan (HSP) is self-insured and administered by BCBSIL.

Plan Sponsor and Administrator

CVS Pharmacy, Inc. (and its participating affiliates) sponsors the CVS Health Welfare Benefit Plan. A complete list of employers sponsoring the Plan is available for examination and may be obtained by written request to the Plan Administrator.

You may contact the Plan Sponsor at:

CVS Pharmacy, Inc.
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

The Plan Administrator is the Executive Vice President and Chief Human Resources Officer of CVS Pharmacy, Inc. Communications to the Plan Administrator should be directed as follows:

Attn: Lisa Bisaccia
Executive Vice President and Chief Human Resources Officer
CVS Pharmacy, Inc.
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

Except to the extent delegated, the Plan Administrator has the sole discretionary authority to interpret the terms of the plan. The Plan Administrator has delegated the discretionary authority to determine all claims under the plan. Such discretionary authority is intended to include, but is not limited to, the determination of whether a person is entitled to benefits under the plan and the computation of any and all benefit payments. The Plan Administrator also delegates to Caremark PCS Health the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial that has been appealed by a claimant or his or her duly authorized representative.

Except with regard to administrative authority delegated above, the Plan Administrator shall have the sole discretionary authority to construe the terms of the plan and all facts surrounding claims under the plan (such as whether an individual is eligible for coverage under the plan), and shall determine all questions arising in the administration, interpretation and application of the plan. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

Agent for Service of Legal Process

CT Corporation System
155 South Main Street, Suite 301
Providence, Rhode Island 02903

Process may also be served on the Plan Administrator.

Named Fiduciary

The named fiduciary is the Executive Vice President and Chief Human Resources Officer of CVS Pharmacy, Inc. Communications to the named fiduciary should be directed to:

Attn: Lisa Bisaccia
Executive Vice President and Chief Human Resources Officer
CVS Pharmacy, Inc.
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

A fiduciary exercises discretionary authority or control over management of the plan or the disposition of its assets, renders investment advice to the plan, or has discretionary authority or responsibility in the administration of the plan.

The “Named Fiduciary” is the one named in the plan, which is the plan Administrator. The named fiduciary can appoint others to carry out fiduciary responsibilities under the plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will generally not be liable for any act or omission of such person.

Claims Fiduciary

While the Plan Administrator is the Named Fiduciary, Blue Cross & Blue Shield of Illinois is the Claims Administrator, and is the plan fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the plan.

Claims Administrator

Blue Cross & Blue Shield of Illinois is the plan’s Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the plan’s coverage as directed by the Plan Administrator, through an administrative agreement with the Company. As Claims Administrator, Blue Cross & Blue Shield of Illinois receives, processes, and pays for the benefits under the plan. With regard to administrative authority delegated to the Claims Administrator, the Claims Administrator shall have the sole discretionary authority to construe the terms of the plan and all facts surrounding claims under the plan, and shall determine all questions arising in the administration, interpretation and application of the plan. All determinations of the Claims Administrator shall be conclusive and binding on all parties.

Blue Cross and Blue Shield of Illinois shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor’s plan. Blue Cross and Blue Shield of Illinois shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor’s plan.

You may contact Blue Cross and Blue Shield of Illinois by phone at the number on your ID card or in writing at:

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

COBRA Administrator

Aon Hewitt
myHR
P.O. Box 563927
Charlotte, NC 28256
(888)694-7287

myHR

CVS Health
P.O. Box 1135
Woonsocket, RI 02895
Attention: FSS Benefits Administration
1-888-MY-HR-CVS (1-888-694-7287)

PLAN IS NOT AN EMPLOYMENT CONTRACT

Enrollment in the plan is not to be construed as a contract for or of employment. Accordingly, nothing in this document says or should be read to imply that participation in the plan is a guarantee of employment with CVS.

FUTURE OF THE PLAN

The continued maintenance of the plan is completely voluntary on the part of CVS and neither its existence nor its continuation will be construed as creating any contractual right to or obligation for its future continuation. While CVS expects to continue the plan indefinitely, CVS reserves the right at any time and for any reason, in its sole discretion, to curtail benefits under, otherwise amend, modify, or terminate the plan or any portion thereof without notice, including, without limitation, those portions of the plan outlining the benefits provided or the classes of employees or dependents eligible for benefits under the plan. The plan may be amended by the Board of Directors of CVS Health Corporation, by the Management Planning and Development Committee, or, in certain circumstances, by approval of the Executive Vice President and Chief Human Resources Officer of CVS Pharmacy, Inc. Any claims requested after the effective date of termination, modification, or amendment are payable in accordance with the respective plan documents. However, no amendment or termination can reduce or otherwise affect any claim for a benefit you became entitled to before the date of amendment or termination. In the event the plan terminates, you will be informed of any termination rights you may have.

DEFINITIONS

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care 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.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle 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.

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 Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

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.

AVERAGE DISCOUNT PERCENTAGE (“ADP”).....means a percentage discount determined by Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois to be relevant to the particular Claim. The ADP reflects Blue Cross and Blue Shield of Illinois’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 “Blue Cross and Blue Shield of Illinois’s Separate Financial Arrangements with Providers.”) In determining the ADP applicable to a particular Claim, Blue Cross and Blue Shield of Illinois will take into account differences among Hospitals and other facilities, Blue Cross and Blue Shield of Illinois’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 plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH CARE UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits including Preauthorization, 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 Disorders.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorders.

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

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
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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
- (ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A “Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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; (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.

A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who has a written agreement with Blue Cross and

Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CLAIM.....means notification in a form acceptable to Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois and a particular Provider. (See provisions of this benefit booklet regarding “Blue Cross and Blue Shield of Illinois’s Separate Financial Arrangements with Providers.”)

CLAIM PAYMENT.....means the benefit payment calculated by Blue Cross and Blue Shield of Illinois, 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 Blue Cross and Blue Shield of Illinois and a particular Provider. (See provisions of this benefit booklet regarding “Blue Cross and Blue Shield of Illinois’s Separate Financial Arrangements with Providers.”)

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.

A “Participating Clinical Laboratory” means a Clinical Laboratory which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Laboratory” means a Clinical Laboratory which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois 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.

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

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.

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. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

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

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 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 (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DESIGNATED DISPENSING ENTITY.....means a pharmacy or other provider that has entered into an agreement with us or with an organization contracting on our behalf, to provide specialty medications for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Participating Provider does not mean that it is a Designated Dispensing Entity. If you are directed to a Designated Dispensing Entity and you choose not to obtain your specialty medication from a Designated Dispensing Entity, you will be subject to the Non-Participating Provider benefit terms for that specialty medication.

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 and electromyograms.

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.

An “Administrator Dialysis Facility” means a Dialysis Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue

Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

A “Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, such 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 Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

- (i) the Provider’s billed charges, or;
- (ii) Blue Cross and Blue Shield of Illinois non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating 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 on the information submitted on the Claim, the Eligible Charge for Non-Participating Providers will be 50% of the Non-Participating Provider’s standard billed charge for such Covered Service.

Blue Cross and Blue Shield of Illinois will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating Providers which may also alter the Eligible Charge for a particular service. In the event Blue Cross and Blue Shield of Illinois does not have any Claim edits or rules, Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois within 145 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 AND ENROLLMENT section of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services.

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 (or, with respect to a pregnant woman, the health of the woman or her unborn child) 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 Disorder 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.

EMPLOYER.....means the company with which you are employed.

EMPLOYER HOSPITAL.....means the Hospital that is your employer.

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

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the plan.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

A “Participating Home Infusion Therapy Provider” means a Home Infusion Therapy Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Home Infusion Therapy Provider” means a Home Infusion Therapy Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service.

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 duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

A “Participating Hospital” means a Hospital that has an agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A “Non-Participating Hospital” means a Hospital that does not meet the definition of a Participating Hospital.

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

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 Disorders or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorders. Dual diagnosis programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that you will benefit from programs that focus solely on Mental Illness conditions. Dual diagnosis programs are delivered by Behavioral Health Practitioners who are cross-trained.

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 or a Partial Hospitalization Treatment Program.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

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.

A “Participating Marriage and Family Therapist” means a Marriage and Family Therapist who has a written agreement with Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois 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 Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of:

- (i) the Provider’s billed charges, or;
- (ii) Blue Cross and Blue Shield of Illinois non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements 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 Non-Participating 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 on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 50% of the Non-Participating Professional Provider’s standard billed charge for such Covered Service.

Blue Cross and Blue Shield of Illinois will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider

Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event Blue Cross and Blue Shield of Illinois does not have any Claim edits or rules, Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois 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.....See EXCLUSIONS section..

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. w1395 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. w1395 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 those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

“Serious Mental Illness”.....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- (i) Schizophrenia;
- (ii) Paranoid and other psychotic disorders;
- (iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) Major depressive disorders (single episode or recurrent);
- (v) Schizoaffective disorders (bipolar or depressive);

- (vi) Pervasive developmental disorders;
- (vii) Obsessive-compulsive disorders;
- (viii) Depression in childhood and adolescence;
- (ix) Panic disorder;
- (x) Post-traumatic stress disorders (acute, chronic, or with delayed onset);
and
- (xi) Anorexia nervosa and bulimia nervosa.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

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.

A “Participating Optometrist” means an Optometrist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Orthotic Provider” means an Orthotic Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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 Blue Cross and Blue Shield of Illinois approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

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

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

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

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

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.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PODIATRIST.....means a duly licensed podiatrist.

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

PREEXISTING CONDITION.....means any disease, illness, sickness, malady or condition for which medical advice, diagnosis, care or treatment was received or recommended by a Provider within 6 months prior to your Enrollment Date. Taking prescription drugs is considered medical treatment even if your condition was diagnosed more than 6 months before your Enrollment Date. For purposes of this definition, pregnancy or conditions based solely on genetic information are not preexisting conditions.

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.

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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.

A “Participating Provider” means a Hospital or Professional Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by Blue Cross and Blue Shield of Illinois as a Participating Provider.

A “Non-Participating Provider” means a Hospital or Professional Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which

has not been designated by Blue Cross and Blue Shield of Illinois as a Participating Provider.

A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan.

A “Participating Prescription Drug Provider” means a Pharmacy that has a written agreement with Blue Cross and Blue Shield of Illinois or the entity chosen by Blue Cross and Blue Shield of Illinois to administer its prescription drug program to provide services to you at the time you receive the services.

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

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.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Registered Surgical Assistant” means a Registered Surgical Assistant who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders.

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.

A “Participating Retail Health Clinic” means a Retail Health Clinic which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Retail Health Clinic” means a Retail Health Clinic which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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.

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

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.

SPECIALTY MEDICATIONS.....means medications defined as certain pharmaceutical and/or biotech or biological drugs (including “biosimilars” or “follow-on biologics”) which are used in the management of chronic or genetic disease, including but not limited to, injectables, infused, inhaled or oral medications, or otherwise require special handling.

SPEECH THERAPIST.....means a duly licensed speech therapist.

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.

SUBSTANCE USE DISORDER.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation 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. 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 Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

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 Blue Cross and Blue Shield of Illinois.

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 jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

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.

GENERAL PROVISIONS

1. BLUE CROSS AND BLUE SHIELD OF ILLINOIS'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield of Illinois hereby informs you that it has contracts with certain Providers (“PPO Network 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 Blue Cross and Blue Shield of Illinois is a party, including all persons covered under The Plan. Those contracts include the terms under which the Providers will be reimbursed for those services. When calculating The Plan’s and the Covered Person’s liability for those services, the negotiated price can be determined by the one of the following methods:

- The actual price, or
- An average discount percentage determined by projections based on historical experience, or
- An average price determined by provider groupings.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by Blue Cross and Blue Shield of Illinois as described in this SPD and the calculation of all required deductible and Coinsurance amounts payable by you as described in this SPD 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. In situations where an estimated or average discount percentage price is used, the actual payment to the provider may be greater or less than the estimated or average discount percentage price. However, the amount paid by CVS and the Covered Person is the final price.

Blue Cross and Blue Shield of Illinois hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois (“Host Blue”) may have contracts similar to the contracts described above with certain Providers (“Host Blue Providers”) in their service area. When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with Blue Cross and Blue Shield of Illinois, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Illinois.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your health care *provider*. Sometimes, it is an estimated price that takes into account special arrangements with your health care *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 health care *providers* after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your *claim* because they will not be applied retroactively to *claims* already paid.

If you need Emergency Care, the Plan will cover you at the highest level that federal regulations allow. You will have to pay for any charges that exceed the Eligible Charge as well as for any Deductibles, Coinsurance, Copayments, and amounts that exceed any Benefit Maximums.

Certain laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- Under this Plan, the Blue Cross and Blue Shield of Illinois has the right to make any benefit payment either to you or directly to the Provider of the Covered Services
- Once Covered Services are rendered by a Provider, you have no right to request Blue Cross and Blue Shield of Illinois not to pay the Claim submitted by such Provider and no such request will be given effect.
- A Covered Person’s claim for benefits under this Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity

3. YOUR PROVIDER RELATIONSHIPS

- The choice of a Provider is solely your choice and Blue Cross and Blue Shield of Illinois will not interfere with your relationship with any Provider.
- Blue Cross and Blue Shield of Illinois does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you.

- The use of the terms such as Participating, Network 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.
- Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individual Covered Person) or your Employer's ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield of Illinois under The Plan as described in this benefit booklet must be in writing and sent to Blue Cross and Blue Shield of Illinois at its offices at 300 East Randolph, Chicago, Illinois 60601.

5. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any entity having knowledge of or records relating to any illness or injury for which a Claim for benefits are made under The Plan are furnish to Blue Cross and Blue Shield of Illinois or its agent, and agree that any such entity may furnish to Blue Cross and Blue Shield of Illinois or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such Claim. In addition, Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois 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 Blue Cross and Blue Shield of Illinois be able to make Claim Payments in accordance with MSP laws.

ASO-1

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www.bcbsil.com/cvs

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