

BlueCross BlueShield of Illinois

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

300 East Randolph Street, Chicago, IL 60601 • 1-800-477-2000

Your Health Care Benefits Program

bcbsil.com

Or call us at the phone number on your member ID card.

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A message from

BLUE CROSS AND BLUE SHIELD

Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois will provide the health care benefit program described in this Policy. In this Policy we refer to our company as “Blue Cross and Blue Shield” or “Blue Cross and Blue Shield of Illinois” and we refer to the Health Insurance Marketplace as the Exchange. Any reference to “applicable law” will include applicable laws and rules, including but not limited to statutes, ordinances, administrative decisions, and regulations. Please read this entire Policy very carefully. We hope that most of the questions you have about your coverage will be answered.

This Policy is currently certified by the Exchange as a Qualified Health Plan.

THIS POLICY REPLACES ANY PREVIOUS POLICY YOU MAY HAVE BEEN ISSUED BY BLUE CROSS AND BLUE SHIELD.

If you have any questions once you have read this Policy, please contact your local Blue Cross and Blue Shield office. It is important to all of us that you understand the protection this coverage gives you. Should you have any questions regarding your eligibility under this Policy, please contact your local Blue Cross and Blue Shield office.

Welcome to Blue Cross and Blue Shield! We are happy to have you as a member and pledge you our best service.

Sincerely,



Brian Snell

President, Illinois Division
Blue Cross and Blue Shield of Illinois

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OUTLINE OF COVERAGE

MAJOR MEDICAL EXPENSE COVERAGE

Blue Choice Preferred Bronze PPO℠ Standard - Select Rx Copays℠

Blue Choice Preferred PPO℠ Network

- **READ THE POLICY CAREFULLY** – This outline of coverage provides a brief description of the important features of the Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ THE POLICY CAREFULLY!**
- This coverage is designed to provide you with economic incentives for using designated health care Providers. It provides, to persons insured, coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services, and Out-of-Hospital care, subject to any Deductibles, Copayment provisions, or other limitations which may be set forth in the Policy. **Although you can go to the Hospitals and Physicians of your choice, your benefits under the Policy will be greater when you use the services of designated Hospitals and Physicians.**
- Each benefit period a calendar year Deductible must be satisfied before benefits will begin, except for Preventive Care Services and other Covered Services not subject to a Deductible. Many of the expenses incurred for Covered Services will also be applied towards the calendar year Deductible, but some will not. Refer to the Policy for more information.

Changes in some state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

BASIC PROVISIONS	**Blue Choice Preferred Bronze PPO℠ Standard - Select Rx Copays**	
	YOUR COST	
Individual Deductible Per individual, per calendar year. (If you have Family Coverage, each member of your family must satisfy his/her own individual deductible.) Not all expenses will apply to this Deductible	Participating Provider Preferred Participating Pharmacy, Participating Pharmacy, and Preferred Specialty Pharmacy	**$7,500**
	Non-Participating Provider Non-Participating Pharmacy and Non-Preferred Specialty Pharmacy	**$15,000**

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Family Deductible If you have Family Coverage and your family has satisfied the family Deductible amount specified, it will not be necessary for anyone else in your family to meet a calendar year Deductible in the benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the calendar year Deductible before receiving benefits. Not all expenses will apply to this Deductible	Participating Provider Preferred Participating Pharmacy, Participating Pharmacy, and Preferred Specialty Pharmacy	**$15,000**
	Non-Participating Provider Non-Participating Pharmacy and Non-Preferred Specialty Pharmacy	**$45,000**
Individual Out-of-Pocket Expense Limit Not all costs count towards this limit	Participating Provider Preferred Participating Pharmacy, Participating Pharmacy, and Preferred Specialty Pharmacy	**$10,000**
	Non-Participating Provider	**Unlimited**
Family Out-of-Pocket Expense Limit Not all costs count towards this limit	Participating Provider Preferred Participating Pharmacy, Participating Pharmacy, and Preferred Specialty Pharmacy	**$20,000**
	Non-Participating Provider Preferred Participating Pharmacy, Participating Pharmacy, and Preferred Specialty Pharmacy	**Unlimited**
Inpatient Hospitals Benefits Including, but not limited to Daily bed, board and general nursing care, and ancillary services (i.e., operating rooms, drugs, surgical dressings, and lab work).		
	YOUR COST	
	Participating Provider	50% Coinsurance after Deductible

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Inpatient Hospital Covered Services	Non-Participating Provider	50% Coinsurance after Deductible
Inpatient Hospital	Participating Provider	None
	Non-Participating Provider	$2,000 per admission
Outpatient Hospital Benefits Including, but not limited to Surgery, Diagnostic Services, radiation, therapy, Chemotherapy, electroconvulsive therapy, renal dialysis treatments and continuous ambulatory peritoneal dialysis treatment, coordinated home care program, pre-admission testing, partial hospitalization treatment program, Autism Spectrum Disorders, habilitative services, surgical implants, maternity services, abortion care, and urgent care.		
Outpatient Hospital Covered Services (except for surgical sterilization procedure)	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Surgical sterilization procedure	Participating Provider	None
	Non-Participating Provider	50% Coinsurance after Deductible
Outpatient Diagnostic X-Ray Services from a Participating Provider	Freestanding Facility	50% Coinsurance after Deductible
	Hospital Setting	50% Coinsurance after Deductible
Outpatient Diagnostic X-Ray Services from a Non-Participating Provider	50% Coinsurance after Deductible	
Outpatient Laboratory from a Participating Provider	Freestanding Facility	50% Coinsurance after Deductible
	Hospital Setting	50% Coinsurance after Deductible
Outpatient Laboratory Services from a Non-Participating Provider	50% Coinsurance after Deductible	
Outpatient Surgery from a Participating Provider	Freestanding Facility	50% Coinsurance after Deductible
	Hospital Setting	50% Coinsurance after Deductible
Outpatient Surgery from a Non-Participating Provider	$2,000 Copayment, then 50% Coinsurance after Deductible	
Certain Diagnostic Tests from a Participating Provider: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI)	Freestanding Facility	50% Coinsurance after Deductible
	Hospital Setting	50% Coinsurance after Deductible

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Certain Diagnostic Tests from a Non-Participating Provider: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI)	50% Coinsurance after Deductible	
Urgent Care Facility visit from a Participating Provider	$75 per Visit, no Deductible	
Hospital Emergency Care		
	YOUR COST	
Emergency Accident Care from either a Participating or Non-Participating Provider	50% Coinsurance after Deductible	
Emergency Medical Care, Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department from either a Participating or Non-Participating Provider	50% Coinsurance after Deductible	
Emergency department services that are not Emergency Accident Care, Emergency Medical Care, or Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Emergency Room (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	50% Coinsurance after Deductible	
Physician Benefits Surgery, anesthesia, assistant surgeon, Medical Care, treatment of illness, consultations, mammograms, Outpatient periodic health examinations, routine pediatric care, Diagnostic Services, injected medicines, amino acid-based elemental formulas, electroconvulsive therapy, radiation therapy, Chemotherapy, cancer medications, Outpatient rehabilitative therapy, Autism Spectrum Disorders , habilitative services, rehabilitative services, Outpatient respiratory therapy, chiropractic and osteopathic manipulation, hearing screening, diabetes self-management training and education, pediatric vision care, dental accident care, family planning services, Outpatient contraceptive services, bone mass measurement and osteoporosis, investigational cancer treatment, Infertility treatment, mastectomy related services, maternity services, abortion care, and urgent care.		
	YOUR COST	
Surgical/Medical Covered Services	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible

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Outpatient office visits	Participating Provider	$50 per Visit, no Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Outpatient Specialist office visits	Participating Provider	$100 per Visit, no Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Surgical sterilization procedures	Participating Provider	None
	Non-Participating Provider	50% Coinsurance after Deductible
Outpatient Mental Illness and Substance Use Disorder Office Visit (Participating Providers)	$50 per Visit, no Deductible	
Chiropractic and Osteopathic Manipulation	25 visit maximum per calendar year	
Naprapathic Services	15 visit maximum per calendar year	
Emergency Accident Care from either a Participating or Non-Participating Provider	50% Coinsurance after Deductible	
Emergency Medical Care, Mental Illness or Substance Use Disorder services provided in a Hospital emergency department from either a Participating or Non-Participating Provider	50% Coinsurance after Deductible	
Emergency department services that are not Emergency Accident Care, Emergency Medical Care, Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Other (Miscellaneous) Covered Services Blood and blood components; Ambulance Transportation, medical and surgical dressings, supplies, casts and splints, prosthetic devices, orthotic devices and durable medical equipment.	50% Coinsurance after Deductible	

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Preventive Care Services from a Participating Provider Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, Deductible, Copayment or dollar maximum (to be implemented in the quantities and within the time period allowed under the applicable law or regulatory guidance): 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 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 additional preventive care and screenings 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).	None	
Preventive Care Services from a Non-Participating Provider	50% Coinsurance after Deductible	
Virtual Visits Benefits will be provided for Covered Services described in the Policy for the diagnosis and treatment of non-emergency medical and behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit.	Primary Care	$50 per Visit, no Deductible
	Specialist	$100 per Visit, no Deductible
	Urgent Care	$75 per Visit, no Deductible
Telehealth and Telemedicine Services	Benefits paid the same as any other office visit	
Outpatient Infusion Therapy Benefits for routine Maintenance Drugs from a Participating Provider	Home, Office, or Infusion Suites	$100 per visit, no Deductible
	Outpatient Hospital	$100 per visit, no Deductible

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Non-Maintenance Drugs	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Hearing Aid Benefits		
Benefit Period	24 months	
Benefit maximum	None	
Benefit payment level	50% Coinsurance after Deductible	
Number of Hearing Aids per ear, each Benefit Period	One	

*The calendar year Deductible, Copayment amount and Out-of-Pocket expense limit amounts may be subject to change or increase as permitted by applicable law or regulatory guidance.

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OUTPATIENT PRESCRIPTION DRUG PROGRAM

Please refer to the Outpatient Prescription Drug Program Section of your Policy for additional information regarding how payment is determined. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives.

Benefits are available for contraceptive drugs and products shown on the *Contraceptive Coverage List* and will not be subject to any Deductible, Coinsurance Amount and/or Copayment Amount when received from a Participating Pharmacy Provider. Your share of the cost for all other contraceptive drugs and products will be provided as shown below.

If you or your Provider requests a Brand Name Drug when a Generic Drug or therapeutic equivalent is available, you will be responsible for the Non-Preferred Brand Name Drug payment amount, plus the difference in cost between the Brand Name Drug and the generic or therapeutic equivalent, except as otherwise provided in the Policy. Any “differences” between the cost of the Generic Drug and the cost of the Brand Name Drug will apply to the deductible or Out-of-pocket maximum. The applicable cost-sharing (by tier) and the cost difference between the generic and brand will never exceed the overall actual price of the drug.

Your Benefits for Outpatient Prescription Drugs and related services purchased at a Participating Pharmacy are subject to the applicable Benefit Period Deductible referenced in the Covered Services document as the members Deductible shall apply to Prescription Drugs purchased from tiers 2 through 4.

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

The amount you may pay for a twin-pack of Medically Necessary epinephrine injectors, regardless of type, shall not exceed $60, when obtained from a Participating Pharmacy, after your program deductible has been met.

PREFERRED PARTICIPATING PHARMACY OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Tier 1	$25 per prescription
Tier 2	$50 per prescription
Tier 3	$100 per prescription

PARTICIPATING PHARMACY OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Tier 1	$25 per prescription
Tier 2	$50 per prescription
Tier 3	$100 per prescription
PHARMACY MATCH PROGRAM **Coverage for certain Covered Drugs are limited to a 30-day supply. However, some Covered Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your plan benefits. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.**	
Tier 4	$500 per prescription

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HOME DELIVERY PRESCRIPTION DRUG PROGRAM **Coverage for certain Covered Drugs are limited to a 30-day supply. However, some Covered Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your plan benefits. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.**	
Tier 1	$75 per prescription
Tier 2	$150 per prescription
Tier 3	$300 per prescription

Certain contraceptive drugs may be available at no cost to you. Please see the Outpatient Prescription Drug Program Benefit Section of the Policy, for additional information.

NON-PARTICIPATING PHARMACY— OUTPATIENT PRESCRIPTION DRUG PROGRAM

*When Covered Drugs are obtained, including diabetic supplies from a Non-Participating Pharmacy benefits will be provided at 50% of the amount that would have been received had the drugs been obtained from a Participating Pharmacy Provider minus the Deductible, if any. If an Out-of-Pocket expense limit is shown above for Non-Participating Providers, then only the Deductible, if any, Copayment Amount and Coinsurance Amount will apply towards the above Out-of-Pocket expense limit for Non-Participating Providers. However, no other expenses at such Non-Participating Pharmacy will apply towards the Out-of-Pocket expense limit.

Your Benefits for Outpatient Prescription Drugs and related services purchased at an Out-of-Network Pharmacy are subject to the applicable Benefit Period Deductible referenced in the Covered Services document as the members Deductible shall apply to Prescription Drugs purchased from tiers 2 through 4.

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Schedule of Pediatric Vision Coverage
For Covered Persons Under Age 19

Pediatric Vision Care Services	**Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider** (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	**Allowance when Covered Services are received from a Non-Participating Vision Provider** (Maximum amount payable under the Policy, not to exceed the retail costs)**
Exam (with dilation as necessary; routine eye examinations do not include professional services for contact lenses):	No Copayment	Up to $30
Frames:		
Any available frame at provider location.	$150 allowance, 20% off balance over $150.	$75
Frequency: Examination, Lenses or Contact Lenses Frame	 Once every 12-month benefit period Once every 12-month benefit period	
Standard Plastic, Glass or Polycarbonate Spectacle Lenses:		
Single Vision	No Copayment	Up to $25
Bifocal	No Copayment	Up to $40
Trifocal	No Copayment	Up to $55
Lenticular	No Copayment	Up to $55
Standard Progressive Lens	No Copayment	Up to $55
Lens Options (add to lens costs above): UV Treatment	No Copayment	Up to $12
Standard Plastic Scratch Coating	No Copayment	Up to $12
Standard Polycarbonate -	No Copayment	Up to $32
Photocromic/ Transitions Plastic	No Copayment	Up to $57
Contact Lenses: (Contact lens allowance includes materials only)	100% coverage for Provider-designated contact lenses	N/A
Extended Wear Disposables	Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	$150

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Pediatric Vision Care Services	Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	Allowance when Covered Services are received from a Non-Participating Vision Provider (Maximum amount payable under the Policy, not to exceed the retail costs)**
Daily Wear / Disposable	Up to 3 months supply of daily disposable, single vision spherical contact lenses	$150
Conventional	1 pair of contact lenses	$150
Medically Necessary contact lenses – Preauthorization is required to be considered for benefits (see details below)	$0 Copay, Paid-in-Full	$210
Contact lenses covered under the Policy are limited to the Provider-designated contact lenses. The Participating Vision Provider will inform you of the contact lens selection covered under the Policy. If you select a lens that is not included in the pediatric lens selection covered under the Policy, you are responsible for the difference in cost between the Participating Vision Provider reimbursement amount for covered contact lenses and the retail price of the contact lenses selected. Any amount 1) paid to the Participating Vision Provider for the difference in cost of a non-Provider-designated contact lens or 2) that exceeds the maximum amount payable for Non-Participating Vision Provider supplied contact lenses will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket expense limit/Out-of-Pocket coinsurance maximum.		
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.		

Value-added features:

Laser vision correction: You will receive a discount for traditional LASIK and custom LASIK from Participating Physicians and contracted laser centers. You must obtain Preauthorization for this service in order to receive coverage. Prices/discounts may vary by state and are subject to change without notice.

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Additional Benefits
Medically Necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism. Medically necessary contact lenses are covered in lieu of other eyewear. Participating Providers will obtain the necessary preauthorization for these services.
Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and Optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. With prior approval from Blue Cross and Blue Shield of Illinois, covered persons who required low-vision services and optical devices are entitled to the following coverage, with both Participating and Non-Participating Providers: **Low Vision Evaluation:** One comprehensive evaluation every five years (Non-Participating Allowance of $300). This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision. **Low Vision Aid:** Covered for one device per year such as high-power spectacles, magnifiers and telescopes (Non-Participating Allowance of $600 per device and $1200 lifetime). These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's vision goals and lifestyle needs. **Follow-up care:** Four visits in any five-year period (Non-Participating Allowance of $100 per visit).
Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Please ask your Provider for details of the warranty that is available to you.

* The "covered charge" is the rate negotiated with Participating Vision Providers for a particular Covered Service.

** **THE PLAN PAYS THE LESSER OF THE ALLOWANCE NOTED OR THE RETAIL COST. RETAIL PRICES VARY BY LOCATION.**

YOU WILL BE RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWANCE AND THE BILLED CHARGES, WHEN RECEIVING COVERED SERVICES FROM A NON-PARTICIPATING PROVIDER.

TO IDENTIFY NON-PARTICIPATING AND PARTICIPATING VISION PROVIDERS, HOSPITALS OR FACILITIES, VISIT EYEMED'S WEBSITE AT www.eyemed.com AND USE THE FIND A PROVIDER LINK (CHOOSE THE SELECT NETWORK FOR YOUR SEARCH), OR CALL 1-844-684-2254.

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EXCLUSIONS AND LIMITATIONS:

Hospitalization, services and supplies which are not Medically Necessary.

Services or supplies that are not specifically mentioned in the Policy.

The Plan does not allow for any services, supplies, drugs, or devices (collectively referred to in this section as ('services') provided to the Member outside of Illinois, if the services are available in Illinois, with the following exceptions:

1 Emergency or urgent care
2 Services provided after the Member is granted an approved service area waiver. The process to obtain a service area waiver is explained below.
3 Services provided to the Member by a provider contracted with the applicable Blue Cross and/or Blue Shield plan in any county in Wisconsin, Indiana, Iowa, Missouri, or that is contiguous to Illinois.

For more information about which counties are contiguous to Illinois, contact the number on the back of the Member's ID card.

Service Area Waiver

BCBSIL members will be required to have a service area waiver on file prior to obtaining any non-emergent or nonurgent services outside of Illinois or from a provider not contracted with a Blue Cross and/or Blue Shield plan in a county contiguous to Illinois, for services that would otherwise be available in Illinois.

Waiver requests may be submitted by either the Member or a provider. Please refer to the plan website or call the customer service telephone number on the back of the Member's ID card. The waiver request will be reviewed by BCBSIL, and a response will be provided to the Member no more than 15 days following receipt of the request.

BCBSIL will review the waiver request to (i) determine the location of the service being requested, (ii) verify if provider is contracted with the Blue Cross and/or Blue Shield plan operating the in location of the service being requested, and (iii) determine whether the service is otherwise available in Illinois. If the service being requested is available through a provider located in Illinois or through a provider contracted with the Blue Cross and/or Blue Shield plan in a contiguous county, the service area waiver will be denied.

If approved, service area waivers will be granted for a period of 60 days or such longer period approved by

Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions.).

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

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

Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

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

Special braces, specialized equipment, appliances, or ambulatory apparatus, except as specifically mentioned in the Policy.

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

Eyeglasses, contact lenses or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye which are not Medically Necessary, except as specifically mentioned in the Policy. This is exclusion is not applicable to children as described in the Policy.

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

Immunizations, unless otherwise specified in the Policy.

Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in the Policy.

Acupuncture, whether for medical or anesthesia purposes.

Maintenance Care.

Hearing Aids, except for bone anchored Hearing Aids (osseointegrated auditory implants), or examinations for the prescription or fitting of Hearing Aids, unless otherwise

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BCBSIL. A new service area waiver is required if an extension is needed at the end of the approved waiver period or if changes resulting in a change in care setting.

Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a Claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

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

Services 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.

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

Custodial Care Service.

Long Term Care Service.

specified in the Policy. This exclusion is not applicable to children as described in the Policy.

Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in the Policy.

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

Notwithstanding any provision in the Policy to the contrary, any services and/or supplies provided to you outside the United States, unless you receive Emergency Accident Care or Emergency Medical Care.

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

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Respite Care Service, except as specifically mentioned under the Hospice Care Program section of the Policy.

Inpatient Private Duty Nursing.

Diagnostic Service as part of 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 Experimental/Investigational, unless otherwise specified in the Policy.

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

Wigs: This plan provides benefits for one wig per benefit period (also referred to as a cranial prostheses) for hair loss when caused by: Chemotherapy, Radiation therapy; or Alopecia

Services and supplies rendered or provided for human organ or tissue transplants other than those specifically mentioned in the Policy.

Reversals of vasectomies.

Any related services to a non-Covered Service except for routine patient care for participants in an Approved Clinical Trial.

Any drugs and medicines, except as may be provided under Outpatient Prescription Drug Program Benefits, that are:

- Dispensed by a Pharmacy and received by you while covered under the Policy,

- Dispensed in a Provider's office or during confinement in a Hospital or other acute care institution or facility and received by you for use on an Outpatient basis,

- Over-the-counter drugs and medicines; or drugs for which no charge is made,

- Prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.

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

Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes, except for Covered Services provided by appropriate Providers as defined in this Policy. Any of the following applied behavior analysis (ABA) related services;

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

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

- Activities primarily of an educational nature;

- Shadow or companion services; or

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

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SCHEDULE PAGE

Plan Name: Blue Choice Preferred Bronze PPO℠ Standard - Select Rx Copays

Network Name:Blue Choice Preferred PPO

Type of Coverage:Individual

BASIC PROVISIONS	Blue Choice Preferred Bronze PPO℠ Standard - Select Rx Copays	
	YOUR COST	
Individual Deductible Per individual, per calendar year. (If you have Family Coverage, each member of your family must satisfy his/her own individual deductible.) Not all expenses will apply to this Deductible	Participating Provider Preferred Participating Pharmacy, Participating Pharmacy, and Preferred Specialty Pharmacy	**$7,500**
	Non-Participating Provider Non-Participating Pharmacy and Non-Preferred Specialty Pharmacy	**$15,000**
Family Deductible If you have Family Coverage and your family has satisfied the family Deductible amount specified, it will not be necessary for anyone else in your family to meet a calendar year Deductible in the benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the calendar year Deductible before receiving benefits. Not all expenses will apply to this Deductible	Participating Provider Preferred Participating Pharmacy, Participating Pharmacy, and Preferred Specialty Pharmacy	**$15,000**
	Non-Participating Provider Non-Participating Pharmacy and Non-Preferred Specialty Pharmacy	**$45,000**
Individual Out-of-Pocket Expense Limit Not all costs count towards this limit	Participating Provider Preferred Participating Pharmacy, Participating Pharmacy, and Preferred Specialty Pharmacy	**$10,000**
	Non-Participating Provider	**Unlimited**

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Family Out-of-Pocket Expense Limit Not all costs count towards this limit	Participating Provider Preferred Participating Pharmacy, Participating Pharmacy, and Preferred Specialty Pharmacy	**$20,000**
	Non-Participating Provider Preferred Participating Pharmacy, Participating Pharmacy, and Preferred Specialty Pharmacy	**Unlimited**
Inpatient Hospitals Benefits Including, but not limited to Daily bed, board and general nursing care, and ancillary services (i.e., operating rooms, drugs, surgical dressings, and lab work).		
	YOUR COST	
Inpatient Hospital Covered Services	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Inpatient Hospital	Participating Provider	None
	Non-Participating Provider	$2,000 per admission
Outpatient Hospital Benefits Including, but not limited to Surgery, Diagnostic Services, radiation, therapy, Chemotherapy, electroconvulsive therapy, renal dialysis treatments and continuous ambulatory peritoneal dialysis treatment, coordinated home care program, pre-admission testing, partial hospitalization treatment program, Autism Spectrum Disorders, habilitative services, surgical implants, maternity services, abortion care, and urgent care.		
Outpatient Hospital Covered Services (except for surgical sterilization procedure)	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Surgical sterilization procedure	Participating Provider	None
	Non-Participating Provider	50% Coinsurance after Deductible
Outpatient Diagnostic X-Ray Services from a Participating Provider	Freestanding Facility	50% Coinsurance after Deductible
	Hospital Setting	50% Coinsurance after Deductible

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Outpatient Diagnostic X-Ray Services from a Non-Participating Provider	50% Coinsurance after Deductible	
Outpatient Laboratory from a Participating Provider	Freestanding Facility	50% Coinsurance after Deductible
	Hospital Setting	50% Coinsurance after Deductible
Outpatient Laboratory Services from a Non-Participating Provider	50% Coinsurance after Deductible	
Outpatient Surgery from a Participating Provider	Freestanding Facility	50% Coinsurance after Deductible
	Hospital Setting	50% Coinsurance after Deductible
Outpatient Surgery from a Non-Participating Provider	$2,000 Copayment, then 50% Coinsurance after Deductible	
Certain Diagnostic Tests from a Participating Provider: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI)	Freestanding Facility	50% Coinsurance after Deductible
	Hospital Setting	50% Coinsurance after Deductible
Certain Diagnostic Tests from a Non-Participating Provider: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI)	50% Coinsurance after Deductible	
Urgent Care Facility visit from a Participating Provider	$75 per Visit, no Deductible	
Hospital Emergency Care		
	YOUR COST	
Emergency Accident Care from either a Participating or Non-Participating Provider	50% Coinsurance after Deductible	
Emergency Medical Care, Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department from either a Participating or Non-Participating Provider	50% Coinsurance after Deductible	

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Emergency department services that are not Emergency Accident Care, Emergency Medical Care, or Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Emergency Room (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	50% Coinsurance after Deductible	
Physician Benefits Surgery, anesthesia, assistant surgeon, Medical Care, treatment of illness, consultations, mammograms, Outpatient periodic health examinations, routine pediatric care, Diagnostic Services, injected medicines, amino acid-based elemental formulas, electroconvulsive therapy, radiation therapy, Chemotherapy, cancer medications, Outpatient rehabilitative therapy, Autism Spectrum Disorders , habilitative services, rehabilitative services, Outpatient respiratory therapy, chiropractic and osteopathic manipulation, hearing screening, diabetes self-management training and education, pediatric vision care, dental accident care, family planning services, Outpatient contraceptive services, bone mass measurement and osteoporosis, investigational cancer treatment, Infertility treatment, mastectomy related services, maternity services, abortion care, and urgent care.		
	YOUR COST	
Surgical/Medical Covered Services	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Outpatient office visits	Participating Provider	$50 per Visit, no Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Outpatient Specialist office visits	Participating Provider	$100 per Visit, no Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Surgical sterilization procedures	Participating Provider	None
	Non-Participating Provider	50% Coinsurance after Deductible
Outpatient Mental Illness and Substance Use Disorder Office Visit (Participating Providers)	$50 per Visit, no Deductible	
Chiropractic and Osteopathic Manipulation	25 visit maximum per calendar year	

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Naprapathic Services	15 visit maximum per calendar year	
Emergency Accident Care from either a Participating or Non-Participating Provider	50% Coinsurance after Deductible	
Emergency Medical Care, Mental Illness or Substance Use Disorder services provided in a Hospital emergency department from either a Participating or Non-Participating Provider	50% Coinsurance after Deductible	
Emergency department services that are not Emergency Accident Care, Emergency Medical Care, Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible
Other (Miscellaneous) Covered Services Blood and blood components; Ambulance Transportation, medical and surgical dressings, supplies, casts and splints, prosthetic devices, orthotic devices and durable medical equipment.	50% Coinsurance after Deductible	
Preventive Care Services from a Participating Provider Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, Deductible, Copayment or dollar maximum (to be implemented in the quantities and within the time period allowed under the applicable law or regulatory guidance): 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 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 additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening	None	

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and mammography and prevention will be considered the most current (other than those issued in or around November 2009).		
Preventive Care Services from a Non-Participating Provider	50% Coinsurance after Deductible	
Virtual Visits Benefits will be provided for Covered Services described in the Policy for the diagnosis and treatment of non-emergency medical and behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit.	Primary Care	$50 per Visit, no Deductible
	Specialist	$100 per Visit, no Deductible
	Urgent Care	$75 per Visit, no Deductible
Telehealth and Telemedicine Services	Benefits paid the same as any other office visit	
Outpatient Infusion Therapy Benefits for routine Maintenance Drugs from a Participating Provider	Home, Office, or Infusion Suites	$100 per visit, no Deductible
	Outpatient Hospital	$100 per visit, no Deductible
Non-Maintenance Drugs	Participating Provider	50% Coinsurance after Deductible
	Non-Participating Provider	50% Coinsurance after Deductible

Hearing Aid Benefits	
Benefit Period	24 months
Benefit maximum	None
Benefit payment level	50% Coinsurance after Deductible
Number of Hearing Aids per ear, each Benefit Period	One

*The calendar year Deductible, Copayment amount and Out-of-Pocket expense limit amounts may be subject to change or increase as permitted by applicable law or regulatory guidance.

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OUTPATIENT PRESCRIPTION DRUG PROGRAM

Please refer to the Outpatient Prescription Drug Program Section of your Policy for additional information regarding how payment is determined. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives.

Benefits are available for contraceptive drugs and products shown on the *Contraceptive Coverage List* and will not be subject to any Deductible, Coinsurance Amount and/or Copayment Amount when received from a Participating Pharmacy Provider. Your share of the cost for all other contraceptive drugs and products will be provided as shown below.

If you or your Provider requests a Brand Name Drug when a Generic Drug or therapeutic equivalent is available, you will be responsible for the Non-Preferred Brand Name Drug payment amount, plus the difference in cost between the Brand Name Drug and the generic or therapeutic equivalent, except as otherwise provided in the Policy. Any “differences” between the cost of the Generic Drug and the cost of the Brand Name Drug will apply to the deductible or Out-of-pocket maximum. The applicable cost-sharing (by tier) and the cost difference between the generic and brand will never exceed the overall actual price of the drug.

Your Benefits for Outpatient Prescription Drugs and related services purchased at a Participating Pharmacy are subject to the applicable Benefit Period Deductible referenced in the Covered Services document as the members Deductible shall apply to Prescription Drugs purchased from tiers 2 through 4.

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

The amount you may pay for a twin-pack of Medically Necessary epinephrine injectors, regardless of type, shall not exceed $60, when obtained from a Participating Pharmacy, after your program deductible has been met.

PREFERRED PARTICIPATING PHARMACY OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Tier 1	$25 per prescription
Tier 2	$50 per prescription
Tier 3	$100 per prescription

PARTICIPATING PHARMACY OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Tier 1	$25 per prescription
Tier 2	$50 per prescription
Tier 3	$100 per prescription
PHARMACY MATCH PROGRAM **Coverage for certain Covered Drugs are limited to a 30-day supply. However, some Covered Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your plan benefits. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.**	
Tier 4	$500 per prescription

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HOME DELIVERY PRESCRIPTION DRUG PROGRAM **Coverage for certain Covered Drugs are limited to a 30-day supply. However, some Covered Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your plan benefits. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.**	
Tier 1	$75 per prescription
Tier 2	$150 per prescription
Tier 3	$300 per prescription

Certain contraceptive drugs may be available at no cost to you. Please see the Outpatient Prescription Drug Program Benefit Section of the Policy, for additional information.

NON-PARTICIPATING PHARMACY— OUTPATIENT PRESCRIPTION DRUG PROGRAM

*When Covered Drugs are obtained, including diabetic supplies from a Non-Participating Pharmacy benefits will be provided at 50% of the amount that would have been received had the drugs been obtained from a Participating Pharmacy Provider minus the Deductible, if any. If an Out-of-Pocket expense limit is shown above for Non-Participating Providers, then only the Deductible, if any, Copayment Amount and Coinsurance Amount will apply towards the above Out-of-Pocket expense limit for Non-Participating Providers. However, no other expenses at such Non-Participating Pharmacy will apply towards the Out-of-Pocket expense limit.

Your Benefits for Outpatient Prescription Drugs and related services purchased at an Out-of-Network Pharmacy are subject to the applicable Benefit Period Deductible referenced in the Covered Services document as the members Deductible shall apply to Prescription Drugs purchased from tiers 2 through 4.

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Schedule of Pediatric Vision Coverage
For Covered Persons Under Age 19

Pediatric Vision Care Services	**Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider** (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	**Allowance when Covered Services are received from a Non-Participating Vision Provider** (Maximum amount payable under the Policy, not to exceed the retail costs)**
Exam (with dilation as necessary; routine eye examinations do not include professional services for contact lenses):	No Copayment	Up to $30
Frames:		
Any available frame at provider location.	$150 allowance, 20% off balance over $150.	$75
Frequency: Examination, Lenses or Contact Lenses Frame	 Once every 12-month benefit period Once every 12-month benefit period	
Standard Plastic, Glass or Polycarbonate Spectacle Lenses:		
Single Vision	No Copayment	Up to $25
Bifocal	No Copayment	Up to $40
Trifocal	No Copayment	Up to $55
Lenticular	No Copayment	Up to $55
Standard Progressive Lens	No Copayment	Up to $55
Lens Options (add to lens costs above): UV Treatment	No Copayment	Up to $12
Standard Plastic Scratch Coating	No Copayment	Up to $12
Standard Polycarbonate -	No Copayment	Up to $32
Photocromic/ Transitions Plastic	No Copayment	Up to $57
Contact Lenses: (Contact lens allowance includes materials only)	100% coverage for Provider-designated contact lenses	N/A
Extended Wear Disposables	Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	$150

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Pediatric Vision Care Services	**Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider** (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	**Allowance when Covered Services are received from a Non-Participating Vision Provider** (Maximum amount payable under the Policy, not to exceed the retail costs)**
Daily Wear / Disposable	Up to 3 months supply of daily disposable, single vision spherical contact lenses	$150
Conventional	1 pair of contact lenses	$150
Medically Necessary contact lenses – Preauthorization is required to be considered for benefits (see details below)	$0 Copay, Paid-in-Full	$210
Contact lenses covered under the Policy are limited to the Provider-designated contact lenses. The Participating Vision Provider will inform you of the contact lens selection covered under the Policy. If you select a lens that is not included in the pediatric lens selection covered under the Policy, you are responsible for the difference in cost between the Participating Vision Provider reimbursement amount for covered contact lenses and the retail price of the contact lenses selected. Any amount 1) paid to the Participating Vision Provider for the difference in cost of a non-Provider-designated contact lens or 2) that exceeds the maximum amount payable for Non-Participating Vision Provider supplied contact lenses will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket expense limit/Out-of-Pocket coinsurance maximum.		
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.		

Value-added features:

Laser vision correction: You will receive a discount for traditional LASIK and custom LASIK from Participating Physicians and contracted laser centers. You must obtain Preauthorization for this service in order to receive coverage. Prices/discounts may vary by state and are subject to change without notice.

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Additional Benefits
Medically Necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism. Medically necessary contact lenses are covered in lieu of other eyewear. Participating Providers will obtain the necessary preauthorization for these services.
Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and Optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. With prior approval from Blue Cross and Blue Shield of Illinois, covered persons who required low-vision services and optical devices are entitled to the following coverage, with both Participating and Non-Participating Providers: **Low Vision Evaluation:** One comprehensive evaluation every five years (Non-Participating Allowance of $300). This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision. **Low Vision Aid:** Covered for one device per year such as high-power spectacles, magnifiers and telescopes (Non-Participating Allowance of $600 per device and $1200 lifetime). These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's vision goals and lifestyle needs. **Follow-up care:** Four visits in any five-year period (Non-Participating Allowance of $100 per visit).
Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Please ask your Provider for details of the warranty that is available to you.

* The "covered charge" is the rate negotiated with Participating Vision Providers for a particular Covered Service.

** **THE PLAN PAYS THE LESSER OF THE ALLOWANCE NOTED OR THE RETAIL COST. RETAIL PRICES VARY BY LOCATION.**

YOU WILL BE RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWANCE AND THE BILLED CHARGES, WHEN RECEIVING COVERED SERVICES FROM A NON-PARTICIPATING PROVIDER.

TO IDENTIFY NON-PARTICIPATING AND PARTICIPATING VISION PROVIDERS, HOSPITALS OR FACILITIES, VISIT EYEMED'S WEBSITE AT www.eyemed.com AND USE THE FIND A PROVIDER LINK (CHOOSE THE SELECT NETWORK FOR YOUR SEARCH), OR CALL 1-844-684-2254.

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RIGHT TO EXAMINE THIS POLICY

You have the right to examine this Policy for a 10-day period after its issuance. If for any reason you are not satisfied with the health care benefits described in this Policy, you may return this Policy and identification card(s) to Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, A Mutual Legal Reserved Company, an Independent Licensee of the Blue Cross and Blue Shield Association (herein called "Blue Cross and Blue Shield of Illinois," "Blue Cross and Blue Shield,' and/or "BCBSIL") and void your coverage. Any premium paid to Blue Cross and Blue Shield will be refunded to you, provided that you have not had a Claim paid under this Policy before the end of the 10-day period. Any portion of the premium that was paid by the Advanced Premium Tax Credit will be returned to the Federal Government.

GUARANTEED RENEWABILITY

Coverage under this Policy will be terminated for nonpayment of premiums as described below. Blue Cross and Blue Shield may terminate or refuse to renew this Policy for any of the following reasons.

1. If Blue Cross and Blue Shield ceases to offer a particular type of coverage in the individual market. If this should occur:
    a. You will receive at least 90 days prior written notice or such other notice, if any, required or permitted by applicable law, regulation, or regulatory guidance.
    b. You may convert to any other individual policy offered by Blue Cross and Blue Shield; and
    c. If Blue Cross and Blue Shield should terminate or refuse to terminate this Policy, it must do so uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
2. If Blue Cross and Blue Shield discontinues all health care coverage and does not renew all health insurance Policies, it issues or delivers for issuance in the individual market in the state of Illinois. If this should occur, you will receive at least 180 days prior written notice or such other notice, if any, required or permitted by applicable law, regulation, or regulatory guidance.
3. You no longer reside, live, or work in the Blue Cross and Blue Shield network service area.
4. Failure to pay your premium after your grace period, if any. When you renew Blue Cross and Blue Shield coverage or reenroll by selecting a new product (as defined by applicable law), you will need to be current on your premium payments. Any past due premium payments for coverage we provided must be paid no later than your Coverage Date for the new year, in addition to initial premium charges. New coverage will not be effective until all such payments are made.
5. Other reasons described in this Policy.
6. You are no longer eligible for coverage in a QHP offered through the Exchange.
7. This Policy is terminated or is decertified as a QHP.
8. Your coverage has been rescinded as described under the "Rescission" provision of this Policy.
9. You change from this QHP to another during an annual open enrollment period or special enrollment period.
10. In the event of fraud or intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice or such other notice, if any, required or permitted by applicable law, regulation, or regulatory guidance.
11. Your association membership ceases, if applicable.

THIS POLICY WILL NOT BE TERMINATED OR BE REFUSED TO BE RENEWED BECAUSE OF THE CONDITION OF YOUR HEALTH.

NOTICE OF ANNUAL MEETING

You are hereby notified that you are a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and you are entitled to vote in person, or by proxy, at all meetings of Members of Blue Cross and Blue Shield. The annual meeting is scheduled to be held at our principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The term “Member” as used above refers only to the person to whom this Policy is issued. It does not include any other family members covered under Family Coverage unless such family member is acting on your behalf.

Blue Cross and Blue Shield pays indemnification or advances expenses to a director, officer, employee, or agent consistent with Blue Cross and Blue Shield’s bylaws then in force and as otherwise required by applicable law.

NOTICE

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

Please refer to the provision entitled "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers" in the *General Provisions* section of this Policy for a further explanation of these arrangements.

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a health benefit plan's actuarial value, is not an indicator of the actual amount of expenses that a particular person will be responsible to pay out of his/her own pocket. A person's out of pocket expenses will vary depending on many factors, such as the particular health care services, health care Providers and particular benefit plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular benefit plan.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

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

YOU CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN NON-EMERGENCY SITUATIONS. Except in limited situations governed by the federal No Suprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), Non-Participating Providers furnishing non-emergency services may bill members for any amount up to the billed charge after the Plan has paid its portion of the bill. If you elect to use a Non-Participating Provider, Plan benefit payments will be determined according to your Policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Policy. Participating Providers have agreed to ONLY bill members the cost-sharing amounts. You may obtain further information about the participating status of Professional Providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card.

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DEFINITIONS SECTION

Throughout this Policy, many words are used which have a specific meaning when applied to your healthcare coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Policy, 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, which means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER. When we use the term "benefit program" in this Policy, we are referring to the Plan Name shown on the Schedule Page.

A1C TESTING - means blood sugar level testing used to diagnose prediabetes, type I diabetes, and type II diabetes, and to monitor management of blood sugar levels.

ACUPUNCTURIST - means a duly licensed Acupuncturist operating within the scope of his or her license.

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

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

ADVANCED PREMIUM TAX CREDIT - means a Premium Tax Credit that has been received by a covered person in advance.

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

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

AMBULATORY SURGICAL FACILITY - means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services when operating within the scope of such license.

PLAN 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 Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and Blue Shield Plan at the time Covered Services are rendered.

NON-PLAN AMBULATORY SURGICAL FACILITY - means an Ambulatory Surgical Facility which does not meet the definition of a Plan Ambulatory Surgical Facility.

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

APPROVED CLINICAL TRIAL - means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is one of the following:

1. A federally funded or approved trial;
2. A clinical trial conducted under an FDA investigational new drug application; or

3. A drug that is exempt from the requirement of an FDA investigational new drug application.

AUTISM SPECTRUM DISORDER(S) - means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

AVERAGE DISCOUNT PERCENTAGE ("ADP") - means a percentage discount calculated by Blue Cross and Blue Shield 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, which is relevant to the particular Claim. The ADP reflects Blue Cross and Blue Shield'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 provision of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers"). In determining the ADP applicable to a particular Claim, Blue Cross and Blue Shield will take into account differences among Hospitals and other facilities, Blue Cross and Blue Shield's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors.

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

BEHAVIORAL HEALTH PRACTITIONER - means a Physician or Professional Provider who is duly licensed to render services for Mental Illness or Substance Use Disorder, when operating within the scope of such license.

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

BENEFIT PERIOD - has the meaning set forth in the provision entitled "Benefit Period", except for the Pediatric Vision Care Benefit Period, which is defined in the Pediatric Vision Care section of this Policy.

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

BIOMARKER TESTING - means the analysis of tissue, blood, or fluid biospecimen for the presence of a biomarker, including, but not limited to singly-analyte tests, multi-plex tests, and partial or whole genome sequencing.

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:

1. Is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and

2. Is a graduate of an advanced practice nursing program.

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.

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:

1. Is a graduate of an approved school or nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and

2. Is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

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.

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:

1. Is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and

2. Is a graduate of an advanced practice nursing program.

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.

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 Certified Registered Nurse Anesthetist, who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse (and is operating within the scope of such license); (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

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.

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, when operating within the scope of such license.

CIVIL UNION - means a legal relationship between two persons of either the same sex or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

CLAIM - means notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number,

the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which Blue Cross and Blue Shield may request in connection with services rendered to you.

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 and a particular Provider. (See provision of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers").

CLAIM PAYMENT - means the benefit payment calculated by Blue Cross and Blue Shield, after submission of a Claim, in accordance with the benefits described in this Policy. 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 and a particular Provider. (See provisions of this Policy regarding **"**Blue Cross and Blue Shield'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.

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.

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 to provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR - means a duly licensed Clinical Professional Counselor, when operating within the scope of such license.

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.

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, when operating within the scope of such license.

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.

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

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.

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

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

COINSURANCE - means a percentage of an eligible expense that you are required to pay toward 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. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant who is not premature or preterm.

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

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.).

PARTICIPATING 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 services to participants in the benefit program at the time Covered Services are rendered or is designated as a participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

NON-PARTICIPATING COORDINATED HOME CARE PROGRAM - means a Coordinated Home Care Program which does not have an agreement with a Blue Cross and/or Blue Shield Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

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

COST-SHARING REDUCTIONS - means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an American Indian/Alaskan Native enrolled in a QHP in the Exchange as described under section 1402 of the Affordable Care Act and 45 C.F.R. § 155.20. Cost-Sharing Reductions are discounts that lower the amount you have to pay Out-of-Pocket for Deductibles, Coinsurance, and Copayments. They also lower your Out-of-Pocket maximum. The federal government determines if you are eligible for these savings. The federal government also funds the Cost-Sharing Reductions under your Policy.

COVERAGE DATE - means the date on which your coverage under this Policy begins.

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

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.).

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

DENTIST - means a duly licensed dentist, when operating within the scope of such license.

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-ray, pathology services, Clinical Laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans and positron emission tomography (PET) scans.

DIALYSIS FACILITY - means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services, when operating within the scope of such license.

PARTICIPATING 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 participants in the benefit program at the time Covered Services are rendered or is designated as a participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

NON-PARTICIPATING DIALYSIS FACILITY - means a Dialysis Facility which does not have an agreement with a Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DOMESTIC PARTNER - means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP - means long-term committed relationship of indefinite duration with a person who meets the following criteria:

1. You and your Domestic Partner have lived together for at least 6 months.
2. Neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner.
3. Your Domestic Partner is at least 18 years of age and mentally competent to consent to contract.
4. Your Domestic Partner resides with you and intends to do so indefinitely.
5. You and your Domestic Partner have an exclusive mutual commitment similar to marriage; and
6. You and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

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

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.

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.

EARLY ACQUIRED DISORDER - means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self-help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder, and cerebral palsy.

ELIGIBLE CHARGE - means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan, at the time Covered Services 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 participants in the benefit program, or is not designated as a

Participating Provider by any Blue Cross and/or Blue Shield Plan, at the time Covered Services are rendered, the following amount (unless otherwise required by applicable law or arrangement with the Non-Participating Provider):

1. The lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (A) the Provider's Billed Charges, and (B) an amount determined by Blue Cross and Blue Shield of Illinois to be approximately 105% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

2. If there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection 1. above based upon the information submitted on the Claim, the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (A) the Provider's Billed Charges and (B) an amount determined by Blue Cross and Blue Shield of Illinois to be 150% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

3. If the base Medicare reimbursement amount and the Maximum Allowance cannot be determined under subsections .1 or .2 above, based upon the information submitted on the Claim, then the amount will be 50% of the Provider's Billed Charges, provided, however, that Blue Cross and Blue Shield of Illinois may limit such amount to the lowest contracted rate that Blue Cross and Blue Shield of Illinois has with a Participating Provider for the same or similar service based upon the type of Provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to the member (unless otherwise required by applicable law or arrangement with the Non-Participating Providers).

In addition to the foregoing, the Eligible Charge will be subject in all respects to Blue Cross and Blue Shield of Illinois Claim Payment rules, edits, and methodologies regardless of the Provider's status as a Participating Provider or Non-Participating Provider. (See provision of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

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

EMERGENCY MEDICAL CARE - means services provided for the initial Outpatient treatment, including related Diagnostic Service, of an Emergency Medical Condition.

EMERGENCY MEDICAL CONDITION - means a medical condition manifesting itself by acute symptoms of sufficient severity regardless of the final diagnosis given such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. 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.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

4. Inadequately controlled pain; or

5. With respect to a pregnant woman who is having contractions:

    a. Inadequate time to complete a safe transfer to another Hospital before delivery; or

    b. A transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

EMERGENCY MENTAL ILLNESS or SUBSTANCE USE DISORDER ADMISSION - means an admission for the treatment of Mental Illness or Substance Use Disorder 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.

EMERGENCY SERVICES - means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and, within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

EXCHANGE - (also known as Health Insurance Marketplace) means a governmental agency or non-profit entity that meets the applicable Exchange standards, and other related standards established under the applicable law, and makes Qualified Health Plans (QHPs) available to Qualified Individuals and qualified employers (as these terms are defined by the Exchange). Unless otherwise identified, this term refers to the State Exchanges, regional Exchanges, subsidiary Exchanges, and/or a Federally facilitated Exchange through which this Policy was sold.

EXPERIMENTAL/INVESTIGATIONAL SERVICES AND SUPPLIES - means the use of any treatment, procedure, facility, equipment, drug, device, or supply (including emerging technologies, services, procedures, and service paradigms) not accepted as Standard Medical Treatment for the condition being treated or any of such items requiring Federal or other governmental agency approval, such approval was not granted at the time services were provided. Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, medical treatment includes medical, surgical, mental health treatment, Substance Use Disorder Treatment, or dental treatment.

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States, and:

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

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

FAMILY COVERAGE - means coverage for you the Insured and your eligible dependents under this Policy.

FREESTANDING FACILITY - means an Outpatient services facility that is not covered under a Hospital's written agreement with Blue Cross and Blue Shield and has its own billing number and written agreement with Blue Cross and Blue Shield to provide services to participants in the benefit program at the time services are rendered. Freestanding Facilities may also be referred to as Outpatient Freestanding Facilities.

HABILITATIVE SERVICES - means Occupational Therapy, Physical Therapy, Speech Therapy, and other health care services that help you keep, learn, or improve skills and functioning for daily living, as prescribed by your Physician pursuant to a treatment plan. Examples include therapy for a child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this Policy.

HEALTH INSURANCE MARKETPLACE - SEE DEFINITION OF EXCHANGE.

HEARING AID - means any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold.

HEARING CARE PROFESSIONAL - means a person who is a licensed Hearing Aid dispenser, licensed audiologist, or licensed Physician operating within the scope of such license.

HOME INFUSION THERAPY PROVIDER - means a duly licensed Home Infusion Therapy Provider, when operating within the scope of such license.

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.

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, when operating within the scope of such license.

PARTICIPATING HOSPICE CARE PROGRAM PROVIDER - means a Hospice Care Program Provider which has a written agreement with Blue Cross and Blue Shield to provide care to participants in the benefit program.

NON-PARTICIPATING HOSPICE CARE PROGRAM PROVIDER - means a Hospice Care Program Provider which does not have a written agreement with Blue Cross and Blue Shield to provide care to participants in the benefit program.

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 under state law for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses, when operating within the scope of such license, irrespective of whether the institution provides Surgery on its premises or at another licensed Hospital pursuant to a formal written agreement between the two institutions.

PARTICIPATING HOSPITAL - means a Hospital which has an 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 benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

NON-PARTICIPATING HOSPITAL – means a Hospital that does not meet the definition of a Participating Hospital.

IATROGENIC INFERTILITY – means an impairment of fertility by Surgery, radiation, Chemotherapy, or other medical treatment affecting reproductive organs or processes.

INDIVIDUAL COVERAGE - means coverage under this Policy for you but not your spouse and/or dependents.

INFERTILITY - means a disease, condition, or status characterized by:

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

INFUSION THERAPY - means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "Infusion Therapy" means

that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

IN HOME HEALTH ASSESSMENT - means Covered Services including, but not limited to, health history and blood pressure and blood sugar level screening. The assessment is designed to provide you with information regarding your health that can be discussed with your health care Provider, and is not a substitute for diagnosis, management, and treatment by your health care Provider.

INPATIENT - means that you are a registered bed patient and are treated as such in a health care facility.

INTENSIVE OUTPATIENT PROGRAM - means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder. Requirements: The Blue Cross and Blue Shield requires that any Mental Illness and/or Substance Use Disorder Intensive Outpatient Program must be licensed in the state where it is located or accredited by a national organization that is recognized by the Blue Cross Blue Shield as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

LIFE-THREATENING DISEASE OR CONDITION - means, for the purpose of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

LONG-TERM ANTIBIOTIC THERAPY - means the administration of oral, intramuscular, or intravenous antibiotics singly or in combination for periods of time in excess of 4 weeks.

LONG TERM CARE SERVICES - means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury, or condition.

MAINTENANCE CARE - means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of 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, when operating within the scope of such license.

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.

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, or the amount of reimbursement amount set by the Plan for Providers designated as Participating Professional Providers 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 (unless otherwise required by applicable law or arrangement with the Non-Participating Provider):

1. The Provider's Billed Charges, or

2. 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 represents approximately 105% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Services (unless otherwise required by applicable law or arrangement with the Non-Participating Provider).

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 100% of Blue Cross and Blue Shield of Illinois' rate for such Covered Services according to its current Schedule of Maximum Allowances (unless otherwise required by applicable law or arrangement with the Non-Participating Provider). If there is no rate according to the Schedule of Maximum Allowance, then the Maximum Allowance will be 25% of Billed Charges (unless otherwise required by applicable law or arrangement with the Non-Participating Provider).

MAY DIRECTLY OR INDIRECTLY CAUSE - means the likely possibility that treatment will cause a side effect of Infertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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

MEDICALLY NECESSARY/MEDICAL NECESSITY - means that a specific medical, health care, supply, or Hospital service is required, for the treatment or management of a medical symptom or condition and that the service, supply, or care provided is the most efficient and economical service which can safely be provided. **PLEASE REFER TO THE SECTION ENTITLED** "*Exclusions – What is Not Covered*" for additional information.

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

MENTAL ILLNESS - means a condition or disorder that involves a mental health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders or any mental health condition that occurs during pregnancy or during the postpartum period, including but not limited to, postpartum depression.

MINIMUM ESSENTIAL COVERAGE - has the meaning set forth in the "Special Enrollment" provision.

NAPRAPATH - means a duly licensed Naprapathy, when operating within the scope of such license.

NAPRAPATHIC SERVICES - means the performance of Naprapathic practice by a Naprapath which may legally be rendered by them.

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

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, when operating within the scope of such license.

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

ONGOING COURSE OF TREATMENT - has the meaning set forth in the provision entitled, "Continuity of Care."

OPTOMETRIST - means a duly licensed Optometrist, when operating within the scope of such license.

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.

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, when operating within the scope of such license.

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.

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 approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment in which patients spend days. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an Inpatient unit, i.e., medically supervised by a Physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Participants at this level of care do not require 24-hour supervision and are not considered a resident at the program. Requirements: Blue Cross and Blue Shield requires that any Mental Illness and/or Substance Use Disorder Partial Hospitalization Treatment Program must be licensed in the state where it is located or accredited by a national organization that is recognized by Blue Cross and Blue Shield as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

PARTICIPATING HOSPITAL - SEE DEFINITION OF HOSPITAL.

PARTICIPATING PROFESSIONAL PROVIDER - SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER - SEE DEFINITION OF PROVIDER.

PERMITTED COST SHARING PAYMENTS - means Blue Cross and Blue Shield of Illinois follows the premium payment process established by the Affordable Care Act in accordance with all Federal requirements. Blue Cross and Blue Shield of Illinois does not accept cost-sharing payments from any other third party, which are referred to in this Policy as "Prohibited Third Party Cost Sharing Payments." Blue Cross and Blue Shield of Illinois only accepts cost-sharing payments from:

A. The Member.

B. The Member's family.

C. Blue Cross and Blue Shield of Illinois accepts premium payments from the following third-party entities on behalf of enrollees:

i. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.

ii. An Indian tribe, tribal organization, or urban Indian organization; and

iii. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

D. Blue Cross and Blue Shield of Illinois may accept premium payments on behalf of enrollees from private, not-for-profit foundations, if the payments are:

i. For the entire coverage period of the enrollee's policy.

ii. Based solely on the financial status of the enrollees.

iii. Regardless of the coverage the enrollee chooses; and

iv. Regardless of the enrollee's health status.

E. Blue Cross and Blue Shield of Illinois may accept premium payments on behalf of enrollees from a Trust, Power of Attorney or Legal Guardian.

F. Blue Cross and Blue Shield of Illinois will not construe payments from an employer as impermissible third-party payments, provided such payments do not create an Employee Retirement Income Security Act (ERISA) group health plan and either:

i. The employer facilitates premium payment collection through payroll deduction or a similar method for the employee, and the employer is not paying any part of the premium either directly or through reimbursement; or

ii. The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer in place of group health insurance.

G. Blue Cross and Blue Shield of Illinois will accept payments on behalf of an enrollee directly from an employer engaged in an ICHRA or QSEHRA, or a third-party payment coordination service, when such payments are made using allowable payment methods.

Unauthorized premium and cost-sharing payments paid by a third party will not be credited to the Member's account and will be refunded to the unauthorized payer. If Blue Cross and Blue Shield of Illinois fails to receive payment in full, from an authorized source by the end of any premium grace period, Blue Cross and Blue Shield of Illinois will retroactively terminate or cancel this coverage.

PERMITTED PREMIUM PAYMENTS - means Blue Cross and Blue Shield of Illinois follows the premium payment process established by the Affordable Care Act in accordance with all Federal requirements. Blue Cross and Blue Shield of Illinois does not accept premium payments from any other third party, which are referred to in this Policy as "Prohibited Third Party Premium Payments." Blue Cross and Blue Shield of Illinois only accepts premium payments from:

A. The Member.

B. The Member's family; and

C. Blue Cross and Blue Shield of Illinois accepts premium payments from the following third-party entities on behalf of enrollees:

i. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.

ii. An Indian tribe, tribal organization, or urban Indian organization; and

iii. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

D. Blue Cross and Blue Shield of Illinois may accept premium payments on behalf of enrollees from private, not-for-profit foundations, if the payments are:

i. For the entire coverage period of the enrollee's policy.

ii. Based solely on the financial status of the enrollees.

iii. Regardless of the coverage the enrollee chooses; and

iv. Regardless of the enrollee's health status.

E. Blue Cross and Blue Shield of Illinois may accept premium payments on behalf of enrollees from a Trust, Power of Attorney or Legal Guardian.

F. Blue Cross and Blue Shield of Illinois will not construe payments from an employer as impermissible third-party payments, provided such payments do not create an Employee Retirement Income Security Act (ERISA) group health plan and either:

i. The employer facilitates premium payment collection through payroll deduction or a similar method for the employee, and the employer is not paying any part of the premium either directly or through reimbursement; or

ii. The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer in place of group health insurance.

G. Blue Cross and Blue Shield of Illinois will accept payments on behalf of an enrollee directly from an employer engaged in an ICHRA or QSEHRA, or a third-party payment coordination service, when such payments are made using allowable payment methods.

Unauthorized premium and cost-sharing payments paid by a third party will not be credited to the Member's account and will be refunded to the unauthorized payer. If Blue Cross and Blue Shield of Illinois fails to receive payment in full from an authorized source by the end of any premium grace period, Blue Cross and Blue Shield of Illinois will retroactively terminate or cancel this coverage.

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

PHYSICAL THERAPIST - means a duly licensed physical therapist, when operating within the scope of such license.

PHYSICAL THERAPY - means the treatment of a disease, injury, or condition by physical means by a Physician or a Physical Therapist 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, when operating within the scope of such license.

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

PODIATRIST - means a duly licensed podiatrist, when operating within the scope of such license.

POLICY - means this booklet, the Schedule Page, and your application(s) for coverage under the Blue Cross and Blue Shield benefit program described in this booklet.

POST-SERVICE MEDICAL NECESSITY REVIEW - means a Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service Claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

PRIOR AUTHORIZATION, EMERGENCY MENTAL ILLNESS or SUBSTANCE USE DISORDER ADMISSION REVIEW - means a requirement that you must obtain authorization from Blue Cross and Blue Shield before you receive certain types of Covered Services designated by Blue Cross and Blue Shield.

PREMIUM TAX CREDIT - means a refundable premium tax credit an eligible individual may receive for taxable years ending after December 31, to the extent provided for under applicable law, where the credit is meant to offset all or a portion of the premium paid by the individual for coverage obtained through the Exchange during the preceding calendar year.

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.

PROHIBITED THIRD PARTY COST SHARING PAYMENTS - SEE DEFINITIONS OF PERMITTED COST SHARING PAYMENTS and PERMITTED PREMIUM PAYMENT.

PROHIBITED THIRD PARTY PREMIUM PAYMENTS - SEE DEFINITION OF PERMITTED PREMIUM PAYMENTS.

PROSTHETIC PROVIDER - means a duly licensed prosthetic Provider, when operating within the scope of such license.

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.

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, when operating within the scope of such license.

PARTICIPATING PROVIDER - means a Hospital or Professional Provider that either: (i) has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield to provide services to participants in the benefit program, or; (ii) has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider in the benefit program.

NON-PARTICIPATING PROVIDER - means a Hospital or Professional Provider that either: (i) does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield to provide services to participants in the benefit program, or; (ii) has not been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider in the benefit program.

PROFESSIONAL PROVIDER - means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker, or any Provider designated by Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan.

PARTICIPATING PROFESSIONAL PROVIDER - means a Professional 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 participants in the benefit program or has been designated by a Blue Cross and Blue Shield Plan as a Participating Professional Provider for this Policy.

NON-PARTICIPATING PROFESSIONAL PROVIDER - means a Professional 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 participants in the benefit program. For purposes of the provision of this Policy entitled **"**Warning, Limited Benefits Will Be

Paid When Non-Participating Providers Are Used", a Non-Participating Provider includes, but is not limited to a Non-Participating Professional Provider.

PARTICIPATING PRESCRIPTION DRUG PROVIDER OR PARTICIPATING PHARMACY - means a Preferred or Non-Preferred Pharmacy, including, but not limited to, an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which has a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide services to you at the time Covered Services are rendered.

NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER OR NON-PARTICIPATING PHARMACY - means a Pharmacy, including, but not limited to, an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which (i) has not entered into a written agreement with Blue Cross and Blue Shield or (ii) has not entered into a written agreement with an entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, for such Pharmacy to provide pharmaceutical services to you at the time Covered Services are rendered.

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:

1. Has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year in an organized health services program; or
2. Is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

QUALIFIED ABA PROVIDER - means a Provider operating within the scope of his/her license, registration or certification that has met the following requirements:

For the treatment supervisor/case manager/ facilitator:

1. Master's level, independently licensed Clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided, for services treating Autism Spectrum Disorder (ASD) symptoms with or without applied behavior analysis (ABA) service techniques; or
2. Master's level Clinician whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e., Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst–Doctoral (BCBA-D), to supervise and provide treatment planning, with ABA service techniques; or
3. Clinician who is certified as a Provider under the TRICARE military health system. if requesting to provide ABA services; or
4. Master's level Clinician with a specific professional credential or certification recognized by the state in which the Clinician is located; or
    a. Developmental Therapist with Certified Early Intervention Specialist credential or CEIS; or
    b. If the Doctor of Medicine (MD) prescribes ABA, writes a MD order for services to be provided by a specific person.

For the para-professional / line therapist:

1. Two years of college educated staff person with a Board-Certified Assistant Behavior Analyst (BCABA) for the para-professional/therapist; or
2. A bachelor level or high school graduate or having obtained a GED, or a staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist; or
3. A person who is "certified as a Provider under TRICARE military health system", if requesting to provide ABA services.

QUALIFIED HEALTH PLAN or QHP - means a health care benefit program that has in effect a certification that it meets the applicable government standards, issued, or recognized by each Exchange through which such program is offered.

QUALIFIED INDIVIDUAL - means an individual who has been determined eligible to enroll in this Policy.

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

REGISTERED DIETICIAN - means a duly licensed Clinical Professional Counselor operating within the scope of his or her license.

REGISTERED SURGICAL ASSISTANT - means a duly licensed certified registered surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant, when operating within the scope of such license.

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

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

REHABILITATIVE SERVICES - means including, but not limited to, Speech Therapy, Physical Therapy and Occupational Therapy. Treatment, as determined by your Physician, that must be either (a) limited to therapy which is expected to result in significant improvement in the condition for which it is rendered, except as specifically provided for under the "Autism Spectrum Disorder(s)" provision and the plan must be established before the treatment has begun and must relate to the type, amount, frequency and duration of the therapy and indicate the diagnosis and anticipated goals, or (b) prescribed as preventive or Maintenance Physical Therapy for members affected by multiple sclerosis. "Rehabilitative Services" must be expected to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury or disabling condition.

RENAL DIALYSIS TREATMENT - means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RENEWAL DATE - means January 1st of each year when your health coverage under this Policy renews for another Benefit Period.

RESCISSION - means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

RESIDENTIAL TREATMENT CENTER - means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriated state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and on-site nursing care and supervision for at least one shift a day with on a

call availability for other shifts for patients with Mental Illness and/or Substance Use Disorder. Blue Cross and Blue Shield of Illinois requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located and/or accredited by a national organization that is recognized by Blue Cross and Blue Shield of Illinois as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

RESPITE CARE 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 for you.

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

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.

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.

ROUTINE PATIENT COSTS - means the cost for all items and services consistent with the coverage provided under this Policy that is typically covered for you if you are not enrolled in a clinical trial.

Routine Patient Costs do not include:

1. The investigational item, device, or service, itself.
2. Items and services which are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SKILLED NURSING FACILITY - means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services, when operating within the scope of such license.

PARTICIPATING 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 participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

NON-PARTICIPATING SKILLED NURSING FACILITY - means a Skilled Nursing Facility which does not have an agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

UNCERTIFIED SKILLED NURSING FACILITY - means a Skilled Nursing Facility which does not meet the definition of a Participating 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 technical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skills and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST - means a duly licensed speech therapist, when operating within the scope of such license.

SPEECH THERAPY - means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote the restoration of

a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

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

SUBSTANCE USE DISORDER - means a condition or disorder that falls under any of the Substance Use Disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

SUBSTANCE USE DISORDER TREATMENT - means an organized, intensive, structured, rehabilitative treatment program of either Hospital or Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disabilities or learning disabilities, care in lieu of detention or correctional placement or family retreat.

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.

PARTICIPATING 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 participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider for this Policy by any Blue Cross and/or Blue Shield Plan, at the time Covered Services are rendered.

NON-PARTICIPATING SUBSTANCE USE DISORDER TREATMENT FACILITY - means a Substance Use Disorder Treatment Facility that does not meet the definition of a Participating Substance Use Disorder Treatment Facility.

SURGERY - means the performance of any medically recognized, non-Experimental/Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations, and any other procedures as reasonably approved by Blue Cross and Blue Shield.

TELEHEALTH/TELEMEDICINE SERVICES - means a health service delivered by a health professional licensed, certified, or otherwise entitled to practice in Illinois and acting within the scope of the health professional's license, certification, or entitlement to a patient in a different physical location than the health professional using telecommunications or information technology.

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

TICK-BORNE DISEASE - means a disease caused when an infected tick bites a person and the tick's saliva transmits an infectious agent (bacteria, viruses, or parasites) that can cause illness, including, but not limited to, the following:

1. A severe infection with borrelia burgdorferi.
2. A late stage, persistent, or chronic infection or complications related to such an infection.
3. An infection with other strains of borrelia or a tick-borne disease that is recognized by the United States Centers for Disease Control and Prevention; and
4. With the presence of signs or symptoms compatible with acute infection of borrelia or other Tick-Borne Diseases.

TOBACCO USER - means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred

within the past six months (or such other meaning required or permitted by applicable law or regulatory guidance). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your identification card or visit our website at *www.bcbsil.com*.

TOTALLY DISABLED - means with respect to an eligible person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the eligible person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an eligible person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a similarly situated person of the same age and sex who is in good health.

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

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

VIRTUAL VISIT - means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the Virtual Visits provision under the *Special Conditions* section of this Policy.

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

COVERAGE AND PREMIUM INFORMATION

This Policy contains information about the health care benefit program for you and your eligible dependents if you:

1. Have been determined eligible to enroll through the Exchange.
2. Meet the definition of a Qualified Individual as determined by the Exchange and Blue Cross and Blue Shield, as appropriate, and have received an eligibility determination from the Exchange.
3. Have applied for this coverage through the Exchange and Blue Cross and Blue Shield, as appropriate.
4. Have received a Blue Cross and Blue Shield identification card.
5. Live within Blue Cross and Blue Shield's service area (contact customer service at the telephone number shown on your identification card for information regarding the service area; and,
6. Reside, live or work in the geographic "network service area" designated by Blue Cross and Blue Shield. You may call customer service at the number shown on your identification card to determine if you are in the network service area or log on to the website at *www.bcbsil.com*.

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

Blue Cross and Blue Shield does not accept Prohibited Third Party Premium Payments.

POLICY YEAR

Policy Year means the 12-month period beginning on January 1 of each year.

RESCISSIONS

Any act, practice, or omission that constitutes fraud, or any intentional misrepresentation made by or on behalf of anyone seeking coverage under this Policy, may result in the cancellation of your coverage (and/or your dependent(s) coverage) retroactive to the Coverage Date (a "Rescission"), subject to 30 days prior notification. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates. Any intentional fraudulent misstatements or omissions, or intentional misrepresentation of a material fact on your application, or any act or practice that constitutes fraud may result in a Rescission of your coverage (and/or your dependent(s) coverage) retroactive to the Coverage Date, subject to prior notification. You have the right to appeal this Rescission and an independent third party may review the decision. In the event of a Rescission, Blue Cross and Blue Shield may deduct from the premium refund any amounts made in Claim Payments during this period and you may be liable for any Claim Payment amount greater than the total amount of premiums paid during the period for which Rescission is effected.

In the event your age has been misstated on your application, all premiums due and amounts payable under this Policy shall be calculated as if this Policy had been purchased at the correct age.

At any time when Blue Cross and Blue Shield is entitled to rescind coverage already in force, Blue Cross and Blue Shield may at its option make an offer to reform this Policy already in force or is otherwise permitted to make retroactive changes to this Policy and/or a change in the rating category/level. In the event of reformation, this Policy will be reissued retroactively in the form it would have been issued had the misstated or omitted information been known at the time of application.

YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD

You will receive a Blue Cross and Blue Shield identification card. This card will tell you your Blue Cross and Blue Shield identification number and will be very important to you in obtaining your benefits.

YOUR SCHEDULE PAGE AND "AT A GLANCE" PAGE

A Schedule Page and an "At A Glance page" have been inserted into or provided along with (and are part of) this Policy. The Schedule Page and the "At A Glance" page contain specific information about your coverage including, but not limited to:

1. The amount of your Deductible(s) and/or Copayment(s); and
2. The Hospital and Physician benefit payment levels.

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

If you have Family Coverage, your health care expenses and those of your enrolled spouse and your (or your spouse's) enrolled children who are under age 26 will be covered. All provisions of this Policy that pertain to a spouse also apply to a party of a Civil Union. A Domestic Partner and his/her children who are under age 26 are also eligible dependents. Coverage for children will end on the last day of the calendar month in which their 26th birthday falls. All of the provisions of this Policy that pertain to a spouse also apply to a Domestic Partner.

Hereafter, "child" or "children" means a natural child, a stepchild, a child(ren) of your Domestic Partner, an adopted child (including a child involved in a suit for adoption,) a foster child, a child for whom you are the legal guardian or a child for whom you have received a court order requiring that you are financially responsible for providing coverage under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of these factors.

NOTE: If you are the policyholder and meet the eligibility requirements for benefits under this Certificate, your dependent parents or stepparents may also be eligible for coverage when they live or reside within the network service area for this Certificate.

In addition, enrolled unmarried children will be covered up to age 30 if they:

1. Live within the state of Illinois; and
2. Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
3. Have received a release or discharge other than a dishonorable discharge.

Under Family Coverage, any newborn children will be covered from the moment of birth, as long as you notify Blue Cross and Blue Shield within 31 days of the birth.

Any children who are dependent upon you or other care Providers for support and maintenance because of a disabling condition will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

For purposes of this section, dependent on other care Providers means requiring a Community Integrated Living arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities), the Department of Public Health, or the Department of Public Aid.

Blue Cross and Blue Shield may inquire 60 days prior to the dependent reaching the limiting age, or at any reasonable time thereafter, whether the dependent is in fact a disabled and dependent person. If required, you must provide proof within 60 days of the inquiry that the dependent is a disabled and dependent person. If you do not provide proof within the 60 days, coverage will automatically terminate on the last day of the month for which premium has been paid.

Any children who are under your legal guardianship, in your custody under an interim court order prior to finalization of adoption or placed with you as a foster child will be eligible for coverage.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship).

A Tobacco User may be subject to a premium of up to 1.5 times the rate applicable to those who are not Tobacco User, to the extent permitted by applicable law or regulatory guidance.

APPLYING FOR COVERAGE

You may apply for coverage in a Qualified Health Plan (QHP) through the Exchange for yourself and/or your eligible dependents (see below) by submitting the application(s) for individual medical insurance form, along with any exhibits, appendices, addenda and/or other required information ("application(s)") to Blue Cross and Blue Shield and the Exchange, as appropriate. The application(s) for coverage may or may not be accepted.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, Claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. You will not be discriminated against for coverage under this Policy on the basis of race, color, national origin, disability, age, sex, gender identity, marital status or sexual orientation. Variation in the administration, processes or benefits of this Policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

You may enroll in or change a QHP for yourself and/or your eligible dependents during one of the following enrollment periods. Your and/or your eligible dependents' effective date will be determined by Blue Cross and Blue Shield and the Exchange, as appropriate, depending upon the date your application is received, payment of the initial premiums no later than the day before the effective date of coverage (unless any Advanced Premium Tax Credit is greater than the initial premium), and other determining factors.

ANNUAL OPEN ENROLLMENT PERIOD / EFFECTIVE DATE OF COVERAGE

You may apply for or change coverage in a QHP through the Exchange for yourself and/or your eligible dependents during the annual open enrollment period designated by the Exchange.

When you enroll during the annual open enrollment period you and/or your eligible family dependents' effective date will be the following January 1, unless otherwise designated by the Exchange and Blue Cross and Blue Shield, as appropriate.

Coverage under this Policy is contingent upon timely receipt by Blue Cross and Blue Shield of necessary information and initial premium.

This provision "Annual Open Enrollment Period/Effective Date of Coverage" is subject to change by the Exchange, Blue Cross and Blue Shield, and/or applicable law or regulatory guidance, as appropriate.

SPECIAL ENROLLMENT PERIODS/EFFECTIVE DATES OF COVERAGE

Special enrollment periods have been designated during which you may apply for or change coverage in a QHP through the Exchange for yourself and/or your eligible dependents. You must apply for coverage within 60 days from the date of a special enrollment event in order to qualify for the changes described in this "Special Enrollment Periods/Effective Dates of Coverage" provision.

Unless otherwise designated by the Exchange, if your application is received on or before the day of the qualifying event, the effective date is the first day of the month following the qualifying life event. Unless otherwise designated by the Exchange, if the application is received after the qualifying event, the effective date is the first of the month following the date of receipt of the application.

You must provide acceptable proof of a qualifying event with your application. Special enrollment qualifying events are discussed in detail below. Blue Cross and Blue Shield will review this proof to verify your eligibility for a special enrollment. Failure to provide acceptable proof of a qualifying event with your application will delay or prevent the processing of your application and enrollment in coverage. Please call the customer service number on the back of your identification card or visit our website at *www.bcbsil.com* for examples of acceptable proof for qualifying events.

Special Enrollment Events:

You may reference an up-to-date listing of on-exchange special enrollment qualifying life events via https://getcovered.illinois.gov/special-enrollment-period/special-enrollment.html.

Coverage resulting from any of the special enrollment events is contingent upon timely completion of the application including proof of such event and remittance of the appropriate premiums in accordance with the guidelines as established by the Exchange and Blue Cross and Blue Shield, as appropriate.

This provision "Special Enrollment Periods" is subject to change by the Exchange, Blue Cross and Blue Shield, and/or applicable law or regulatory guidance, as appropriate.

WHO IS NOT ELIGIBLE

Eligibility for this coverage will be determined by the Exchange in accordance with applicable law. For questions regarding eligibility, refer to *www.healthcare.gov.*

PAYMENT OF PREMIUMS

The required premiums are determined and established by Blue Cross and Blue Shield based on many factors, such as the age, place of residence, tobacco use, and the number of eligible dependents covered under this Policy. Premiums will be calculated based on the age of each individual to be included under this Policy.

Note: A Tobacco User may be subject to a premium of up to 1.5 times the rate applicable to those who are not Tobacco User, to the extent permitted by applicable law.

1. Premiums are due and payable on the due date.
2. The initial premium for Individual Coverage is based on your age at the time your coverage begins and the initial premium for Family Coverage is based on your age, your spouse's age and any eligible dependent children at the time coverage is applied for, as permitted by law.
3. Blue Cross and Blue Shield may establish a new premium for any of the benefits of this Policy on any of the following dates or occurrences:
    a. Whenever the benefits of this Policy are increased, which may occur whenever required by law or whenever Blue Cross and Blue Shield gives notice of an increase in benefits.
    b. Whenever the number of persons covered under this Policy is changed.
    c. Whenever you move your residence from one geographical rating area to another.
    d. Whenever there is a change in you or your eligible dependent's Tobacco Use.

    For the purposes of this "Payment of Premium" provision, Tobacco Use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that Tobacco Use does not include religious or ceremonial use of tobacco.
4. If the ages upon which the premium is based have been misstated, an amount which will provide Blue Cross and Blue Shield with the correct premium from your Coverage Date shall be due and payable upon billing or receipt from Blue Cross and Blue Shield.
5. In the event you are not receiving an Advanced Premium Tax Credit, a grace period of 31 days, or such other grace period, if any, permitted by applicable law or regulatory guidance will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force, however, Claim Payments for Covered Services received during the grace period may be pended until full premium payment is made, and during the grace period your Providers and pharmacies may require you to pay for your health care and prescription drug expenses in full. After the grace period, coverage under this Policy will automatically terminate on the last day of the coverage period for which premiums have been paid, unless coverage is extended as described below.

    If you pay your premium in full during the grace period, then you may submit a Claim to Blue Cross and Blue Shield for any expenses that you paid to your Providers and pharmacies during the grace period. See the *How To File a Claim* section for additional information.

If you fail to pay premiums to Blue Cross and Blue Shield and/or the Exchange within the grace period, this Policy will automatically terminate. During such grace period this Policy will continue in force, subject to the right of Blue Cross and Blue Shield to terminate this Policy in accordance with the "Termination of Coverage" provision of this Policy. If coverage is terminated for non-payment of premium, any Claims received and paid for during the grace period will be billed to you.

6. In the event you are receiving an Advanced Premium Tax Credit, you have a three-month grace period, or such other grace period, if any, permitted by applicable law or regulatory guidance for paying the full premiums falling due after the first premium. If full premium is not paid for you and your covered family members within one month of the premium due date, Claim Payments for Covered Services received during the second- and third-month's grace period under this Policy will be pended until full premium payment is made. If full payment of the premium is not made within the grace period, then coverage under this Policy will automatically terminate on the last day of the first month of the grace period. The time periods during which your Claims will be pended are subject to change as permitted by applicable law or regulatory guidance.

   During the grace period, in the event you are receiving an Advanced Premium Tax Credit, Blue Cross and Blue Shield will:

   a. Pay all appropriate Claims for services rendered during the first month of the grace period and may pend Claims for services rendered in the second and third months of the grace period, if any.

   b. Notify the Department of Health and Human Services of such non-payment; and,

   c. Notify Providers of the possibility of denied Claims during the second and third months of your grace period, if any.

The grace periods and time periods during which your Claims will be pended are subject to change as permitted by applicable law or regulatory guidance.

Blue Cross and Blue Shield does not accept payments of premium directly from third parties except for Permitted Premium Payments. Blue Cross and Blue Shield does **not accept Prohibited Third Party Premium Payments**.

REINSTATEMENT

If any premium is not paid within the time granted you for payment, a subsequent acceptance of premium by Blue Cross and Blue Shield and/or the Exchange or by any agent duly authorized by Blue Cross and Blue Shield or by the Exchange to accept such premium, without requiring an application for reinstatement in connection with the premium payment, shall reinstate this Policy. However, if Blue Cross and Blue Shield and/or the Exchange or such agent requires an application for reinstatement and issues a conditional receipt for the premium given, this Policy will be reinstated upon approval of such application by Blue Cross and Blue Shield and/or the Exchange or, lacking such approval, upon the 45th day following the date of such conditional receipt unless Blue Cross and Blue Shield and/or the Exchange has previously notified you in writing of its disapproval of such application.

The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such illness as may begin more than 10 days after such date. In all other respects you will have the same rights as you had under this Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed and attached hereto in connection with reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

During the term of this Policy, if you are activated for military service and become eligible for a federal government-sponsored program as a result of that activation, you (and your covered dependents if you have Family Coverage) may not be denied reinstatement of this Policy after your discharge unless the discharge is under less than honorable conditions or you are no longer an Illinois resident.

TERMINATION OF COVERAGE

Blue Cross and Blue Shield will not terminate coverage for any member based solely on the member's health status or health care needs.

If Blue Cross and Blue Shield terminates this Policy for any reason, Blue Cross and Blue Shield will provide you and the Exchange with a notice of termination of coverage that includes the termination effective date and reason for termination at least 30 days prior to the last day of coverage, or such other notice, if any, required or permitted by applicable law, regulation or regulatory guidance, except as otherwise provided in this Policy.

You and your Eligible Family Members' coverage will be terminated due to the following events and will end on the dates specified below:

1. You terminate your coverage under this Policy, including as a result of your obtaining other Minimum Essential Coverage, with reasonable, appropriate notice to the Exchange and Blue Cross and Blue Shield. For the purposes of this section, reasonable notice is defined as 14 days from the requested effective date of termination.

   The last day of coverage will be:

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

   b. 14 days after the termination is requested by you, if you do not provide reasonable notice: or

   c. On a date determined by Blue Cross and Blue Shield, if Blue Cross and Blue Shield is able to effectuate termination in fewer than 14 days and you request an earlier termination effective date.

2. When you are no longer eligible for QHP coverage through the Exchange. The last day of coverage is the last day of the month following the month in which the notice is sent by the Exchange unless you request an earlier termination effective date.

3. When Blue Cross and Blue Shield does not receive the full amount of the premium payment on time or when there is a bank draft failure of premiums for your and/or your Eligible Family Members 'coverage, and

   a. In the event you are receiving an Advanced Premium Tax Credit, the grace period (described above) for individuals receiving an Advanced Premium Tax Credit (described above) has been exhausted. The last day of coverage will be the last day of the first month of the grace period. Blue Cross and Blue Shield will pay all appropriate Claims for services rendered to you and/or your eligible dependents during the first month of the grace period and may pend Claims for services rendered to you and/or your eligible dependents in the second and third months of the grace period. Or,

   b. In the event you are not receiving an Advanced Premium Tax Credit, after the 31-day grace period (described above) has been exhausted, the last day of coverage will be the last day of the coverage period,

   c. For which premiums have been paid unless coverage is extended as described below. Also, if coverage is terminated, any Claims received and paid for during the grace period will be billed to you.

   Blue Cross and Blue Shield applies its termination policy for non-payment of premium uniformly to enrollees in similar circumstances.

4. Your coverage has been rescinded. For additional information, see the definition of "Rescission" in the *Definitions Section* of this Policy.

5. This QHP terminates or is decertified.

6. You change from this QHP to another during an annual open enrollment period or special enrollment period. The last day of coverage in this QHP is the day before the effective date of coverage in your new QHP.

The above termination events, Claim pend dates and coverage termination dates are subject to change as permitted by applicable law, or regulatory guidance.

Cancellation of your coverage under this Policy terminates the coverage of all your dependents under this Policy.

Benefits will not be provided for any services or supplies received after the date coverage terminates under this Policy, unless specifically stated otherwise in this Policy. However, termination of your coverage will not affect your benefits for any services or supplies that you received prior to your termination date.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Policy is terminated, benefits will be provided for, and limited to, the Covered Services which are provided by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Residential Treatment Center, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until you reach any maximum benefit amount which may apply, whichever occurs first. No other benefits will be provided after your coverage under this Policy is terminated.

EXTENSION OF BENEFITS FOR DEPENDENT STUDENTS DUE TO A MEDICAL LEAVE OF ABSENCE

Coverage will continue under this Policy for a dependent who is unable to maintain full-time student status as a result of a Medically Necessary leave of absence or any other change in enrollment, provided that:

1. The dependent is enrolled under this Policy on the basis of being a student at a post-secondary educational institution; and
2. The dependent was covered immediately before the first day of the Medically Necessary leave of absence or other change in enrollment; and
3. The dependent child's treating Physician provides to Blue Cross and Blue Shield a written certification stating that the child is suffering from a serious illness or injury and that the leave of absence or other change in enrollment is Medically Necessary.

Coverage for such a dependent may be continued under this Policy until the date that is the earlier of:

1. One year after the first day of the Medically Necessary leave of absence or other change in enrollment; or
2. The date on which such coverage would otherwise terminate under the terms of this Policy.

The first day of the Medically Necessary leave of absence will be documented as the date indicated by the Physician in the written certification on which the medical leave or other enrollment change is to begin.

CONTINUITY OF CARE

If you are a covered person under the care of a Participating Provider who stops participating in the Participating Provider Option network (for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by State licensing board)and the Provider remains within the network service area and your Provider agrees, you may be able to continue receiving Covered Services with that Provider, at the Participating Provider benefit level, for the following:

1. An Ongoing Course of Treatment for a serious acute disease or condition requiring complex ongoing care that you are currently receiving (for example, you are currently receiving Chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition).
2. An Ongoing Course of Treatment for a Life-Threatening Disease or Condition and the likelihood of death is probable unless the course of the disease or condition is interrupted.
3. An Ongoing Course of Treatment for the second and third trimester of pregnancy through the postpartum period; or
4. An Ongoing Course of Treatment for a health condition of which a treating Provider attests that discontinuing care by the Participating Provider who is terminating from the network would worsen the condition or interfere with anticipated outcomes.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than ninety (90) days from the date of the notice to the covered person of the Provider's disaffiliation from the Network, or if the covered person has entered the second or third trimester of pregnancy at the time of the Provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery.

If you are a new covered person whose Provider is not Participating, but is within the network service area, you are able to continue receiving Covered Services with that Provider at the Participating Provider benefit level to continue an Ongoing Course of Treatment as stated above, during a transition.

Continuity coverage for a new covered person shall continue until the treatment is complete but will not extend for more than ninety (90) days from the effective date of enrollment, or if the covered person has entered the second or third trimester of pregnancy at the time of the Provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery.

You have the right to appeal any decision made for a request for benefits under this provision as explained in the "Claim Appeal Procedures" provision in the *How To File a Claim* section of this Policy.

CHILD-ONLY COVERAGE

Eligible children that have not attained age 21 may enroll as the enrollee under this health care plan. In such event, this health care plan is considered child-only coverage and the following restrictions apply:

1. The parent or legal guardian is not covered and is not eligible for benefits under this health care plan.
2. **If a child covered under this plan acquires a new eligible child of his/her own, the new eligible child may be enrolled in his/her own plan coverage if application for coverage is made within 30 days.**

If a child is under the age of 18, his/her parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and/or other required information to the Plan and the Exchange, as appropriate. For any child under 18 covered under this health care plan, any obligations set forth in this Plan, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Application for child-only coverage will not be accepted for an adult child that has attained age 21 as of the beginning of the calendar year. Adult children (at least 18 years of age but have not attained age 21) who are applying as the enrollee under this plan must apply for their own individual plan and must sign or authorize the application(s).

BENEFIT INFORMATION

You have chosen a Blue Cross and Blue Shield benefit program for the administration of your Hospital and Physician benefits and all other Covered Services that provides you access to independently contracted Providers participating in the Blue Choice Preferred PPO℠ Network. This program of health care benefits is designed to provide you with economic incentives for receiving Covered Services from designated, Participating Providers.

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

Before reading the description of your benefits, you should understand the terms described below.

BENEFIT PERIOD

The Benefit Period is the period beginning on the Coverage Date and ending on the Termination Date.

YOUR DEDUCTIBLES

Each calendar year you must satisfy the Deductible amount(s) specified on the Schedule Page of this Policy for Covered Services. In other words, after you have Claims for Covered Services for more than the Deductible amount in a calendar year, your benefits will begin. This Deductible will be referred to as the calendar year Deductible.

Each time you are admitted to a Hospital or Non-Plan Hospital you must satisfy the Inpatient Copayment amount (if applicable) specified on the Schedule Page of this Policy. This Copayment is in addition to your calendar year Deductible. This Deductible will be referred to as the Inpatient Hospital Deductible.

Each time you receive Covered Services for Outpatient Surgery in a Hospital, you must satisfy the Outpatient Surgical Deducible amount (if applicable) specified on the Schedule Page of this Policy. This Deductible is in addition to your calendar year Deductible.

If you have Family Coverage and your family has satisfied the family Deductible amount specified on the Schedule Page of this Policy, it will not be necessary for anyone else in your family to meet a calendar year Deductible in the Benefit Period. That is, for the remainder of that Benefit Period, no other family members will be required to meet the calendar year Deductible before receiving benefits.

These Deductible amounts are subject to change or increase as permitted by applicable law.

In any case, should two (2) or more members of your family ever receive Covered Services as a result of injuries received in the same accident; only one calendar year Deductible will be applied against those Covered Services.

TRANSITION OF CARE BENEFITS

If you are a new covered person and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy, and your Physician does not belong to the Network, but is within the Network's service area, you may request the option of transition of care benefits. You must submit a written request to Blue Cross Blue Shield for transition of care benefits. Blue Cross and Blue Shield may authorize transition of care benefits for a period up to 90 days from the effective date of enrollment. Authorization of benefits is dependent on the Physician's agreement to contractual requirements and submission of a detailed treatment plan. A written notice of Blue Cross and Blue Shield's determination will be sent to you.

If you are a covered person under the care of a Participating Provider and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy and your Provider

leaves the Network, you may request the option of continuity of care benefits as described in the “Continuity of Care” provision in the *Coverage and Premium Information* Section of this Policy.

You must submit a written request to Blue Cross and Blue Shield for continuity of care benefits after receiving notification of your Provider’s termination. Blue Cross and Blue Shield may authorize continuity of care benefits for a period up to 90 days from the date of the notice to the covered person of the Provider’s termination from the Network. Authorization of benefits is dependent on the Physician’s agreement to contractual requirements and submission of a detailed treatment plan. A written notice of Blue Cross and Blue Shield’s determination will be sent to you.

UTILIZATION MANAGEMENT AND REVIEW

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on BCBSIL Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity review. If requested, services normally subject to a Post-Service Medical Necessity review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

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

PRIOR AUTHORIZATION

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services for which you have obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

If Prior Authorization is required, the 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. Blue Cross and Blue Shield recommends you confirm with your Provider if Prior Authorization has been obtained.

PRIOR AUTHORIZATION RESPONSIBILITY

Participating Provider Prior Authorization

Your Participating Provider is responsible for obtaining Prior Authorization, in those circumstances where authorization may be required. If Prior Authorization is not obtained and the services are denied as not Medically Necessary, the Participating Provider will be held responsible and will not be able to bill the Member for the services. For additional information about Prior Authorization for services outside of our services area, refer to the Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements Notice in the NOTICES section of this Certificate.

For additional information about Prior Authorization for services outside of our service area, refer to the *Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements Notice* in the **NOTICES** section of this Certificate.

Note: Providers that contract with other Blue Cross and Blue Shield Plans may not be familiar with the Prior Authorization requirements of BCBSIL. Unless a Provider contracts directly with BCBSIL as a Participating Provider, the Provider is not responsible for being aware of this Plan's Prior Authorization requirements, except as described in the section "The BlueCard Program® in the General Provisions".

Non-Participating Provider Prior Authorization

If any Provider outside Illinois (except for those contracting as Participating Providers directly with BCBSIL) or any Non-Participating Provider recommends an Admission or a service that requires Prior Authorization, the Provider is not obligated to obtain the Prior Authorization for you. In such cases, it is your responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, you may be entirely responsible for the charges if determined not to be Medically Necessary. If the service is determined to be Medically Necessary, Out-of-Network Benefits will apply. The Provider may call on your behalf, but it is your responsibility to ensure that BCBSIL is called.

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services for which you have obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

To determine if a specific service or category requires Prior Authorization, visit our website at *www.bcbsil.com/find-care/where-you-go-matters/utilization-management* for the required Prior Authorization list, which is updated when new

services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your identification card to determine if Prior Authorization is required and/or to request a Prior Authorization.

Inpatient Hospital Admissions

Your Physician may need to obtain Prior Authorization from Blue Cross and Blue Shield for an Inpatient admission, if Inpatient admissions are identified as needing a Prior Authorization. In the case of an elective Inpatient admission, if services require an authorization, it is recommended that the call for Prior Authorization should be made as far in advance as possible but minimally within three calendar days before you are admitted unless it would delay Emergency Care. In an emergency, it is recommended that notification should take place as soon as possible but minimally within one calendar day after admission, or as soon thereafter as reasonably possible.

Your Participating Provider is required to obtain Prior Authorization for Inpatient admissions that may require Prior Authorization. If Prior Authorization is not obtained for Inpatient Services and the services are denied as not Medically Necessary, the Participating Provider will be held responsible and will not be able to bill the Member for the services.

If the Physician or Provider of services is not a Participating Provider then you, your Physician, Provider of services, or an authorized representative should obtain Prior Authorization by the Plan by calling one of the toll-free numbers shown on the back of your identification card. The call should be made between 7:00 a.m. and 6:00 p.m., Central Time, on business days and 9:00 a.m. and 3:00 p.m., Central Time on Saturdays, Sundays and legal holidays. After working hours or on weekends, please call the toll-free telephone number listed on the back of your identification card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

When Prior Authorization of an Inpatient Hospital Admission is obtained, a length-of-stay is assigned. Your Provider may seek an extension for the additional days if you require a longer stay. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the **Length of Stay/Service Review** subsection of this Certificate.

NOTE: Prior Authorization is not required for Behavioral Health Inpatient Hospital Admissions at Participating Hospitals. The first 72 hours of such coverage will not be subject to concurrent review if the Participating Hospital notifies BCBSIL of the admission and the initial treatment plan within 48 hours of admission. Please see **Contacting Behavioral Health** section below for more information regarding other Behavioral Health Prior Authorizations or Recommended Clinical Review requests.

Prior Authorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

1. Maternity Care:

a. 48 hours following an uncomplicated vaginal delivery.

b. 96 hours following an uncomplicated delivery by caesarean section.

2. Treatment of Breast Cancer:

a. 48 hours following a mastectomy.

b. 24 hours following a lymph node dissection.

You or your Provider will not be required to obtain Prior Authorization from BCBSIL for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you, your authorized representative, or your Provider must seek an extension for the additional days by obtaining Prior Authorization from BCBSIL.

OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW

If Prior Authorization is required, the 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. BCBSIL recommends you confirm with your Provider if Prior Authorization has been obtained.

There may be general categories of Covered Services that require Prior Authorization.

To determine if a specific service or category requires Prior Authorization, visit our website at *www.bcbsil.com/find-care/where-you-go-matters/utilization-management* for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your identification card.

For Behavioral Health Outpatient Service review please see the **Contacting Behavioral Health** section below.

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 under this Certificate.

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

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the *Appeal Procedure* section under this Certificate.

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

RECOMMENDED CLINICAL REVIEW

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

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

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

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

CONTACTING BEHAVIORAL HEALTH

You, your Physician or Provider of services or your authorized representative may contact BCBSIL for a Prior Authorization or Recommended Clinical Review by calling the toll-free number shown on the back of your identification card and follow the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 6:00 PM, on weekends, and on holidays, the same behavioral health line is answered by Clinicians available for Inpatient acute reviews only. Requests for residential or Partial Hospitalization are reviewed only during regular business hours.

General Provisions Applicable to All Recommended Clinical Reviews

1. No Guarantee of Payment
   A Recommended Clinical Review is not a guarantee of benefits or payment of benefits by the plan. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and Exclusions of this Certificate. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the member may have become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

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

POST-SERVICE MEDICAL NECESSITY REVIEW

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

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment
   A Post-Service Medical Necessity Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and Exclusions of this Certificate. Post-Service Medical Necessity Review does not guarantee payment of benefits by the plan, for instance a member may become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

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

CASE MANAGEMENT

When you receive Covered Services in an emergency room or are hospitalized for a complex medical situation such as an organ transplant, accident or serious disease, you may be contacted by a case manager. Case managers are registered nurses (or other health care professionals) who have professional training and clinical experience. They may:

1. Answer questions about your medical condition.

2. Help you understand what to expect when you are discharged from the Hospital to your home, or to another care facility; and

3. Help coordinate special care you may need.

In some cases, if your condition requires care in a Hospital, or other health care facility, the case manager may provide an alternative treatment plan. If you and your Physician choose the alternative treatment plan, then alternative benefits may be provided as described under this Certificate.

Alternative benefits will be provided only so long as it has been determined 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 Certificate.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. Additionally, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and Exclusions under this Certificate.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care, Outpatient services, behavioral health services or other health care services or supplies are not Medically Necessary will be based on generally accepted medical standards. Should Blue Cross and Blue Shield determine that the Inpatient care, Outpatient services, behavioral health services or other health care services or supplies are not Medically Necessary, written notification of the decision, and your right to request an external review, will be provided to you, your Physician or Behavioral Health Practitioner and/or the Hospital, facility or other Provider, within 24 hours. It will specify the dates or services that are not considered Covered Services. For Inpatient care or behavioral health services, such written notice will be sent within 15 calendar days of the date the decision was made. For further details regarding Medically Necessary care and other Exclusions from coverage under this Certificate, see the sections entitled *Exclusions—What Is Not Covered* and *Definitions.*

Note: If Benefits for Mental Illness or Substance Use Disorders are denied on the grounds that they are not Medically Necessary, you may request an expedited external review.

Blue Cross and Blue Shield 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 Physician. Blue Cross and Blue Shield'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 this Certificate.

Blue Cross and Blue Shield will make the initial decision whether hospitalization, Outpatient service or other health care services or supplies were not Medically Necessary. In most instances, this decision is made by Blue Cross and Blue Shield after you have been hospitalized, or have received other health care services or supplies, and after a Claim for payment has been submitted.

Remember that your Blue Cross and Blue Shield Certificate does not cover the cost of hospitalization, or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve an Inpatient stay, Outpatient service or other health care service, or supplies does not of itself make such admission, service or supplies Medically Necessary. Even if your Physician prescribes, orders,

recommends, approves, or views an admission or other health care services or supplies as Medically Necessary, Blue Cross and Blue Shield will not pay for the admission, services or supplies if Blue Cross and Blue Shield and the Blue Cross and Blue Shield Physician decide they were not Medically Necessary, except as otherwise provided in the *Appeal Procedure* section under this Certificate.

Certain services are covered pursuant to Blue Cross and Blue Shield medical policies and clinical procedure and coding policies, which are updated throughout the plan year. The medical policies are guides considered by Blue Cross and Blue Shield when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the benefit plan. The most up-to-date medical and clinical procedure and coding policies are available at *www.bcbsil.com*, or call customer service at the toll-free telephone number on the back of your identification card.

APPEAL PROCEDURE

If you, or your Physician or Provider of health services, or Behavioral Health Practitioner disagree with the determination of Blue Cross and Blue Shield prior to, or while receiving services, you may appeal that decision by contacting Blue Cross and Blue Shield.

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 Blue Cross and Blue Shield, you may appeal that decision by having your Physician or Provider of health services, or 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
P.O. Box 660603
Dallas, TX 75266-0603

You must exercise the right to an appeal as a precondition to taking any action against Blue Cross and Blue Shield, either at law or in equity.

Additional information about appeals procedures is set forth in the “Claim Appeal Procedures” provision of the *Claim Filing and Appeals Procedures* section under this Certificate.

Failure to Obtain Prior Authorization

If Prior Authorization is not obtained:

1. BCBSIL will review the Medical Necessity of your treatment or service prior to the final benefit determination.
2. If BCBSIL determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.

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 Policy tells you what Hospital services are covered and how much will be paid for each of these services.

As a participant in this benefit program a directory of Participating Hospitals is available to you. You can visit the Blue Cross and Blue Shield of Illinois and/or Exchange website at *www.bcbsil.com* for a list of Participating Hospitals or you can contact customer service and request a copy of the Provider Directory and one will be sent to you. While there may be changes in the directory from time to time, selection of Participating Hospitals by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to you annually, or as required, to allow you to make selections within the Hospital network. However, you are urged to check with your Hospital before undergoing treatment to make certain of its participation status. Although you can go to the Hospital of your choice, Hospital benefits under this benefit program will be greater when you use the services of a Participating Hospital.

The benefits of this section are subject to all of the terms and conditions of this Policy. Please refer to the *Definitions* and *Exclusions – What is Not Covered* sections of this Policy 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. In the case of Inpatient Services, you must be admitted to the Hospital or other Provider on or after your Coverage Date. This means that benefits will not be provided for an Inpatient stay if you were admitted prior to your Coverage Date.

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

INPATIENT COVERED SERVICES

Inpatient Hospital Care

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

1. Bed, board and general nursing care when you are in:
   a. A semi-private room.
   b. A private room (at the common semi-private room rate).
   c. An intensive care unit.
2. Ancillary services (such as operating rooms, drugs, surgical dressings, and lab work, x-ray, pathology services, MRI, CT scan and PET scan).

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

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

Preadmission Testing

This is a program in which 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

Benefits are available for this program only if it is a Blue Cross and Blue Shield approved program. 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.

Inpatient Skilled Nursing Facility Care

Benefits will be provided for the same services that are available to you as an Inpatient in the Hospital. Benefits will not be provided for services received in an Uncertified Skilled Nursing Facility.

Coordinated Home Care

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

Routine Patient Costs for Participants in Approved Clinical Trials

Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Rehabilitative Services

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

After you have met your calendar year Deductible, benefits will be provided as described below.

Each time you are admitted to a Hospital you will also be responsible for the Inpatient Hospital Deductible amount (if applicable) as shown on the Schedule Page of this Policy.

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider, benefits will be provided at the Participating Provider Inpatient Hospital payment level for Participating Providers as shown on the Schedule Page of this Policy. If you are in a private room, but the private room is not Medically Necessary, then benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider, benefits will be provided at the Non-Participating Provider Inpatient Hospital payment level as shown on the Schedule Page of this Policy. 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.

Emergency Admissions

If you must be hospitalized in a Non-Participating Hospital immediately following Emergency Accident Care or Emergency Medical Care, benefits will be provided such that you will have no greater cost than you would for the same Covered Services at a Participating Provider Hospital for that portion of your Medically Necessary Inpatient Hospital stay until such time as your condition allows you to be safely transferred to a Participating Hospital or other Participating Provider.

If your condition is serious, you will be unable to transfer from a Non-Participating Hospital to a Participating Hospital. However, when your condition is no longer serious, you must transfer to a Participating Hospital in order to continue to receive benefits at the Participating payment level.

Services provided in a Hospital emergency department that are not Emergency Medical Care or Emergency Accident Care may be excluded from emergency coverage, although these services may be covered under another benefit, if applicable. Non-emergency services provided in a Hospital emergency department for treatment of Mental Illness or Substance Use Disorder will be paid the same as Emergency Medical Care and Emergency Accident Care services.

TO IDENTIFY NON-PARTICIPATING AND PARTICIPATING HOSPITALS OR FACILITIES, YOU SHOULD CONTACT BLUE CROSS AND BLUE SHIELD BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON

YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD OR VISIT THE BLUE CROSS AND BLUE SHIELD WEBSITE AT *WWW.BCBSIL.COM* FOR A LIST OF PARTICIPATING HOSPITALS.

OUTPATIENT HOSPITAL COVERED SERVICES

The following are Covered Services when you receive them from a Hospital (or other specified Provider) as an Outpatient.

Outpatient Hospital Covered Services

1. **Surgery** and any related Diagnostic Service received on the same day as the Surgery.
2. In addition to Surgery in a Hospital, benefits will be provided for Outpatient Surgery performed in an Ambulatory Surgical Facility.
3. **Radiation therapy treatments** –This plan provides benefits for Medically Necessary radiation therapy treatments, including proton beam therapy.
4. **Reconstructive Services**—
this plan provides benefits for Medically Necessary reconstructive services to restore physical appearence due to trauma.
5. **Chemotherapy.**
6. **Electroconvulsive Therapy.**
7. **Renal Dialysis Treatments**—these treatments are eligible for benefits if you receive them in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility.
8. **Diagnostic Service**—when these services are related to Surgery or Medical Care. Such tests include, but are not limited to, x-ray, pathology services, Clinical Laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.
9. **Emergency Accident Care.**
10. **Emergency Medical Care.**
11. **Urgent Care.**
12. **Mammograms**—Benefits for mammograms will be provided at the benefit payment level described in the *Special Conditions* section of this Policy.
13. **Bone Mass Measurement and Osteoporosis**—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.
14. **Pap Smear Test**—Benefits will be provided for an annual routine cervical smear or Pap smear test. Unless otherwise stated, benefits will be provided at the benefit payment level described in the provision entitled, “Preventive Care Services” in the *Special Conditions* section of this Policy.
15. **Prostate Test and Digital Rectal Examination**—Benefits will be provided for an annual routine prostate routine prostate-specific antigen test and digital rectal examination.
16. **Ovarian Cancer Screening**—Benefits will be provided for annual ovarian cancer screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.
17. **Colorectal Cancer Screening**—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the provision entitled, “Preventive Care Services” in the *Special Conditions* section of this Policy.

18. **Routine Patient Costs for Participants in Approved Clinical Trials**—Benefits for Covered Services for Routine Patients Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

19. **Rehabilitative Services.**

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

Please refer to the *Special Conditions* section of this Policy for benefits for Preventive Care Services.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

After you have met your calendar year Deductible, benefits will be provided as described below:

Each time you are admitted to a Hospital or Non-Participating Hospital you will also be responsible for the Outpatient Hospital Deductible amount (if applicable) as shown on the Schedule Page of this Policy.

Participating Provider

Benefits will be provided at the benefit payment level described on the Schedule Page of this Policy for Outpatient Covered Services received in a Participating Hospital, Participating Ambulatory Surgical Facility or Participating Dialysis Facility.

Non-Participating Provider

Benefits will be provided at the benefit payment level described on the Schedule Page of this Policy when you receive Outpatient Covered Services in a Non-Participating Hospital.

Urgent Care

Each time you receive Covered Services in an urgent care facility from a Participating Provider, you will be responsible for an urgent care facility Copayment amount (if applicable) specified on the Schedule Page of this Policy. Coverage for any additional Covered Services received in the urgent care facility will be provided at the payment levels for Outpatient Hospital Covered Services.

Emergency Care

Benefits for Emergency Accident Care will be provided at the benefit payment level described on the Schedule Page of this Policy when you receive Covered Services, that meet the definition of Emergency Accident Care, from either a Participating or Non-Participating or Non-Plan Provider in a Hospital emergency department.

Benefits for Emergency Accident Care will be subject to the Participating Provider calendar year Deductible.

Benefits for Emergency Medical Care will be provided at the benefit payment level described on the Schedule Page of this Policy when you receive Covered Services, that meet the definition of Emergency Medical Care, from either a Participating or Non-Participating Provider in a Hospital emergency department.

Benefits for Emergency Medical Care will be subject to the Participating Provider calendar year Deductible.

Benefits received for Mental Illness will be provided at the same benefit level specified in the Benefit Highlights of this Policy at no greater cost when you receive Covered Services that meet the definition of Mental Illness, from either a Participating, Non-Participating or Non-Plan Provider in a Hospital emergency department.

Benefits for Mental Illness will be subject to the program Deductible.

Benefits received for Substance Use Disorder will be provided at the same benefit level specified in the Benefit Highlights of this Policy at no greater cost when you receive Covered Services, that meet the definition of Substance Use Disorder, from either a Participating or Non-Participating Provider in a Hospital emergency department.

Benefits for Substance Use Disorder will be subject to the program Deductible.

Each time you receive Covered Services in an emergency room, you may be responsible for an emergency room per occurrence Copayment (if applicable) specified on the Schedule Page of this Policy. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room per occurrence Copayment will be waived.

However, Emergency Medical Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge whether or not you have met your calendar year Deductible. The emergency room Deductible will not apply.

These Copayment and Deductible amounts are subject to change or increase as permitted by applicable law or regulatory guidance.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER HOSPITAL

If you must receive Hospital Covered Services which Blue Cross and Blue Shield has reasonably determined as unavailable from a Participating or Participating Professional Provider, benefits for the Covered Services you receive from a Non-Participating or Non-Participating Professional Provider will be provided such that you will have no greater cost than if you received the Covered Services at a Participating or Participating Professional Provider.

BENEFIT DIFFERENTIALS FOR COVERED SERVICES IN HOSPITAL AND FREESTANDING FACILITY

Benefits for certain Covered Services may vary depending on whether the service was received in a Hospital or a Freestanding Facility.

Benefits for Outpatient Surgery, Certain Diagnostic Tests, Diagnostic X-ray Services and Outpatient Laboratory Services will be at the benefit level set forth in the Schedule Page. Members' out of pocket expenses may be lower when Covered Services are received in a Freestanding Facility instead of a hospital. Further, these cost differentials, if any, only apply to Participating Provider Claims.

Freestanding Facilities are indicated as such in our Provider Finder at *www.bcbsil.com*. You can review the Provider Finder to find Freestanding Facility locations for treatment in your area or you can call the customer service toll-free number on your identification card. Freestanding Facilities may also be referred to as Outpatient Freestanding Facilities.

PHYSICIAN BENEFIT SECTION

This section lists the Covered Services under your Certificate. **Please note that services must be determined to be Medically Necessary by the Plan in order to be covered under this Certificate.** Coverage of items and services provided to you is subject to Blue Cross and Blue Shield of Illinois policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, utilization management, and clinical payment and coding policies, which are updated throughout the plan year. These policies are resources utilized by Blue Cross and Blue Shield of Illinois when making coverage determinations and lay out the procedure and/or criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item. The clinical payment and coding policies are intended to ensure accurate documentation for services performed and require all providers to submit Claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Under the clinical payment and coding policies, Claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines. Coverage for Covered Services is subject to the code edit protocols for services/procedures billed and Claim submissions are subject to applicable Claim review which may include, but is not limited to, review of any terms of benefit coverage, provider contract language, medical and medical management policies, utilization or clinical review or utilization management policies, clinical payment and coding policies as well as coding software logic, including but not limited to lab management or other coding logic or edits.

Any line on the Claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included in the Covered Charge and will not be eligible for payment by the Plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the provider rendering the item or service or submitting the Claim is participating or non-participating. The most up-to-date medical policies and clinical procedure and coding policies are available at *www.bcbsil.com* or by contacting a Customer Service Representative at the number shown on your identification card.

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

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Podiatrist, or Dentist and for any related Diagnostic Services received on the same day as the Surgery. However, for services performed by a Podiatrist or Dentist, benefits are limited to those surgical procedures which may be legally rendered by them, and which would be payable under this Policy had they been performed by a Physician.

Benefits provided for oral Surgery (performed by a Physician or Dentist) are limited to the following services:

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

The following services are also part of your surgical benefits:

1. **Sterilization Procedures** — (even if they are voluntary). Benefits for sterilization procedures and follow-up services will not be subject to any Deductible Coinsurance and/or Copayment when such services are received from a Participating Provider.

2. **Anesthesia**—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 CRNA. However, benefits will be provided for Anesthesia Services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

   In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

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

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

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

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

   a. It is attributable to cerebral palsy, epilepsy or any other condition, other than a Mental Illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;

   b. It is manifested before the age of 22.

   c. It is likely to continue indefinitely; and

   d. It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.

3. **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.

A1C Testing

This plan provides benefits for A1C Testing for prediabetes, type I diabetes, and type II diabetes, in accordance with prediabetes and diabetes risk factors identified by the United States Centers for Disease Control and Prevention.

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge. Your calendar year Deductible will not apply to this benefit. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Benefits are available for Medical Care visits when:

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

Mobile Integrated Health Care Services.

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

Consultations

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

Mammograms

Benefits for mammograms will be provided at the benefit payment level described in the *Special Conditions* section of this Policy.

Electroconvulsive Therapy Radiation Therapy Treatments

Allergy Injections and Allergy Testing

Routine Foot Care

Benefits will be provided for Medically Necessary routine foot care, when obtained from a licensed Provider.

Chemotherapy

Benefits will be provided for non-self-injected intravenous cancer medications that are used to kill or slow the growth of cancerous cells.

Massage Therapy

Medical Benefit Therapeutic Alternatives

Certain prescription drugs administered by a health care professional have therapeutic equivalents or therapeutic alternatives that are used to treat the same condition. Benefits may be limited to only certain therapeutic equivalents or therapeutic alternatives. However, benefits may be provided for the therapeutic equivalents or therapeutic alternatives that are not otherwise covered under your benefit, if an exception is granted.

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

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

NOTE: Coverage will be available for a Brand Name Drug, if a generic drug or therapeutic equivalent is listed as currently in shortage or as a discontinuation in the FDA drug shortages database.

Tobacco Use Screening and Smoking Cessation Counseling Services Tobacco Cessation Drugs

Testing, Screening, Vaccinations, and Treatment obtained through Pharmacies

This plan provides benefits for select Covered vaccinations, including testing, screening and treatments through certain Pharmacies that have contracted with Blue Cross and Blue Shield to provide this service. To locate a contracting Pharmacy in your area, call the Customer Service toll-free number on your identification card.

At the time you receive services, present your Blue Cross and Blue Shield identification card to the pharmacist. This will identify you as a participant in the Blue Cross and Blue Shield health care plan provided by your employer. The pharmacist will inform you of the amount for which you are responsible for, if any.

Pharmacies that have contracted with Blue Cross and Blue Shield to provide this service may have age, scheduling, or other requirements that will apply. You are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this benefit section. Refer to your Blue Cross and Blue Shield medical coverage for benefits available for childhood immunizations.

Benefits for vaccinations that are considered preventive care services will not be subject to any Deductible, Coinsurance Amount, or dollar maximum when such services are received from a Participating Provider or a Pharmacy that is contracted for such service.

Vaccinations that are received from Pharmacies not participating in the vaccination program, a Non-Plan Provider facility, or a Pharmacy that does not have a contract with Blue Cross and Blue Shield, or other routine Covered Services not provided for under this provision may be subject to the Deductible, Coinsurance Amount and/or benefit maximum.

Vitamin D Testing

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

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy and education programs that allow you to maintain a hemoglobin A1C level within the range identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management, operating within the scope of his or her license or certification. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in Other *Covered Services* section of this Policy. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for telehealth/telemedicine regular foot care examinations by a Physician or Podiatrist, and for licensed dietitian nutritionists and certified diabetes educators to counsel diabetics in their home to remove the hurdle of transportation for diabetes patients to receive treatment.

Growth Hormone Therapy

This plan provides benefits for Medically Necessary growth hormone therapy.

Therapies to Treat Menopause

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

Immune Gamma Globulin Therapy (IGGT)

Benefits will be provided for immune gamma globulin therapy for covered persons diagnosed with a primary immune deficiency when prescribed as Medically Necessary by a Physician. Nothing shall prevent Blue Cross and Blue Shield from applying appropriate utilization review standards to the ongoing coverage of IGGT for persons diagnosed with a primary immunodeficiency. Subject to such utilization review standards, an initial authorization shall be for no less than three months

and reauthorization may occur every six months thereafter. For persons who have been in treatment for two years, reauthorization shall be no less than every 12 months, unless more frequently indicated by a Physician.

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)/Pediatric Acute Onset Neuropsychiatric Syndrome (PANS) Treatment

Benefits will be provided for all Medically Necessary treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including coverage for Medically Necessary intravenous immunoglobulin therapy. Immunoglobulin therapy is also known as immune gamma globulin therapy.

Pediatric Neuromuscular, Neurological, or Cognitive Impairment

Benefits will be provided for therapy, diagnostic testing, and equipment, necessary to increase quality of life for children who have been diagnosed with a disease, syndrome, or disorder that includes low tone neuromuscular, neurological, or cognitive impairment.

Fibrocystic Breast Condition

Pulmonary Rehabilitation Therapy

Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Breast Cancer Pain Medication and Therapy

Benefits will be provided for all Medically Necessary pain medication and therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically based and includes reasonably defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Benefits will also be provided for all Medically Necessary pain medication related to the treatment of breast cancer under the *Outpatient Prescription Drug Program Benefit* section of this Policy.

Breast Implant Removal Cardiovascular Disease Management

Diagnostic Service

for those services related to covered Surgery or Medical Care. Such tests include, but are not limited to, x-ray, pathology services, Clinical Laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

Colorectal Cancer Screening

Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the provision entitled, “Preventive Care Services” in the *Special Conditions* section of this Policy.

Emergency Accident Care Emergency Medical Care

Blood Glucose Monitors for Treatment of Diabetes

Benefits are available for Medically Necessary blood glucose monitors (including continuous glucose monitors, non-invasive monitors and monitors for the blind) for which a Health Care Practitioner has written an order. This coverage also includes related supplies, and training in the use of continuous glucose monitors.

Benefits for glucose monitors will be provided at no charge when obtained from a Participating Provider after your program deductible has been met, if applicable.

Prosthetic Appliances

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

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

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, including those determined by your Provider to be most appropriate for physical activities, such as running, biking, swimming and lifting, 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).

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces, and those determined by your Provider to be most appropriate for physical activities, such as running, biking, swimming and lifting. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. Your benefits for foot orthotics will be limited to two-foot orthotic devices or one pair of foot orthotic devices per Benefit Period.

Pancreatic Cancer Screening

This plan provides benefits for Medically Necessary pancreatic cancer screenings.

Biomarker Testing

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

Bone Mass Measurement and Osteoporosis

Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Breast Reduction Surgery

This plan provides benefits for Medically Necessary breast reduction surgery.

Cleft Lip and Palate

This plan provides benefits for Medically Necessary treatment and care for cleft lip and palate for children under the age of 19.

Experimental/Investigational Treatment

Benefits will be provided for routine patient care in conjunction with Experimental/Investigational Treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your Physician is considered a Life Threatening Disease or Condition, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this Policy if not provided in connection with an Approved Clinical Trial program. Approval by a federal agency will be taken into consideration by Blue Cross and Blue Shield in assessing Experimental/Investigational status but will not be determinative. You and your Physician are encouraged to call customer services at the toll-free number on your identification card in advance to obtain information about whether a particular clinical trial is qualified.

Comprehensive Cancer Testing

This plan provides benefits for Medically Necessary Comprehensive Cancer Testing, including, but not limited to, whole-exome genome testing, whole-genome sequencing, RNA sequencing, tumor mutation burden, and targeted cancer gene

panels. This plan also provides benefits for Medically Necessary testing of blood or constitutional tissue for cancer predisposition testing as determined by a licensed Physician.

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 the maximum stated in your Policy. Your benefits for chiropractic and osteopathic manipulation will be limited to 25 visits per Benefit Period.

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. Compression sleeves to prevent or mitigate lymphedema. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of cardiopulmonary monitors or durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Amino Acid-Based Elemental Formulas

Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the benefit payment level for Other Covered Services described in the *Other Covered Services* section of this Policy.

Rehabilitative Services Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a Physician or Physical Therapist; provided however, when the therapy is beyond the scope of the Physical Therapist's license, the Physical Therapist must be under the supervision of a Physician, and therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis.

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Clinical Breast Examinations

Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician. Benefits for clinical breast examinations will be provided at the benefit payment level described in the "Preventive Care Services" provision in the *Special Conditions* section of this Policy.

Diagnostic Colonoscopies

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

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

Human Papillomavirus Vaccine

Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. Unless otherwise stated, benefits will be provided at the benefit payment level described in the provision entitled, “Preventive Care Services” in the *Special Conditions* section of this Policy.

If you obtain the vaccine at a Pharmacy, benefits will be provided at the benefit payment level described in the provision entitled, “Vaccinations obtained through Participating Pharmacies” in the *Outpatient Prescription Drug Program Benefit section* of this Policy.

Shingles Vaccine

Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration.

Routine Liver Screening

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

Outpatient Contraceptive Services

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

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

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or pap smear test. Unless otherwise stated, benefits will be provided at the benefit payment level described in the provision entitled, “Preventive Care Services” in the *Special Conditions* section of this Policy.

Prostate Cancer Screening

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

Ovarian Cancer Screening

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

Prostate Test and Digital Rectal Examination

Benefits will be provided for an annual routine prostate routine prostate-specific antigen test and digital rectal examination for males.

Routine Pediatric Hearing Examination

Benefits will be provided for routine hearing examinations for children up to age 19.

HIV Screening and Counseling

Benefits will be provided for HIV Screening and Counseling and prenatal HIV testing ordered by a Physician, Physician Assistant or Advanced Practice Registered Nurse who has a written collaborative agreement with a collaborating physician

that authorizes these services, including but not limited to orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

Long-term Antibiotic Therapy

Benefits will be provided for Long-term Antibiotic Therapy, including necessary office visits and ongoing testing, for a person with a Tick-Borne Disease when determined to be Medically Necessary and ordered by a Physician after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.

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

Telehealth and Telemedicine Services

Telehealth/Telemedicine Services are covered, as defined in the Schedule Page of this Policy.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by Blue Cross and Blue Shield 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.

After you have met your program calendar year Deductible, benefits will be provided as described below.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at the Participating Provider payment level for Surgical/Medical Covered Services as specified in the Schedule Page of this Policy, after you have met your calendar year Deductible, unless otherwise specified in this Policy. Dentists are not Participating Providers but will be treated as such for purposes of benefit payment made under this Policy and may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

When you receive Covered Services (except for those services specified below) in a Participating Provider's office (other than a specialist's office), benefits for Covered Services, including all related Covered Services received on the same day will be provided at the Physician's office payment level specified on the Schedule Page of this Policy. Your calendar year Deductible will not apply.

When you receive Covered Services (except for those services specified below) in a Participating Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the same day, will be provided at the specialist's office payment level specified on the Schedule Page of this Policy.

When you receive Covered Services for Diagnostic Services or certain Diagnostic tests (CT scan, PET scan, or MRI) you may be responsible for a per procedure Copayment or Coinsurance amount in addition to your calendar year Deductible specified on the Schedule Page of this Policy.

Benefits for certain Diagnostic tests may require a Copayment or Coinsurance amount specified on the Schedule Page of this Policy.

This Copayment or Coinsurance amount is subject to change or increase as permitted by applicable law or regulatory guidance.

A specialist is a Provider who is not a:

1. Behavioral Health Practitioner.
2. Certified Nurse-Midwife.
3. Certified Nurse Practitioner.
4. Certified Clinical Nurse Specialist.

5. Clinical Professional Counselor.
6. Clinical Social Worker.
7. Clinical Laboratory.
8. Marriage and Family Therapist.
9. Mixed psychiatric group.
10. Mixed specialty group.
11. Neuro Psychologist.
12. Optician.
13. Optometrist; or
14. Retail Health.

Clinic or a Physician in:

1. Clinical psychology.
2. Family practice.
3. General practice.
4. Gynecology.
5. Internal medicine.
6. Obstetrics.
7. Obstetrics/gynecology.
8. Pediatrics; or
9. Psychiatry.

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

1. Surgery.
2. Occupational Therapy.
3. Physical Therapy.
4. Speech Therapy.
5. Chiropractic and osteopathic manipulation.
6. Diagnostic Services.
7. CT scan, PET scan and MRI.

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 the Physician payment level for Non-Participating Providers as shown on the on the Schedule Page of this Policy, after you have met your calendar year Deductible.

When you receive Covered Services, in a Participating Hospital or in a Participating Ambulatory Surgical Facility and, due to any reason, Covered Services are provided by an anesthesiologist (including a Certified Registered Nurse Anesthetist,), pathologist, radiologist, neonatologist, emergency room Physician, assistant surgeon (if the primary surgeon is a

Participating Provider) or other Physician who is not a Participating Provider are unavailable from a Participating Provider and Covered Services are provided by a Non-Participating Provider, you will incur no greater Out-of-Pocket costs than you would have incurred if the Covered Services were provided by a Participating Provider. However, in the event that you willfully choose to receive Covered Services in a Participating Hospital or in a Participating Ambulatory Surgical Facility from a Non-Participating Provider who is an anesthesiologist (including a Certified Registered Nurse Anesthetist), pathologist, radiologist, neonatologist, emergency room Physician, assistant surgeon (if the primary surgeon is a Participating Provider) or other Physician, when a Participating Provider is available to provide the Covered Services, the preceding sentence will not apply to you and the Non-Participating Provider benefit level will apply.

Participating and Non-Participating Provider Emergency Care

Benefits for Emergency Accident Care and Emergency Medical Care will be provided at the Physician payment level for Participating Providers as shown on the Schedule Page of this when services, that meet the definition of Emergency Accident Care and Emergency Medical Care, are rendered by either a Participating Provider or a Non-Participating Provider in a Hospital emergency department. Your calendar year Deductible will apply. Non-emergency services provided in a Hospital emergency department for treatment of Mental Illness or Substance Use Disorder will be paid the same as Emergency Medical Care and Emergency Accident Care services.

However, Covered Services received for Emergency Medical Care for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Maximum Allowance whether or not you have met your calendar year Deductible. The office visit Copayment will not apply.

These Copayment amounts are subject to change or increase as permitted by applicable law or regulatory guidance.

Participating Professional Providers are:

1. Acupuncturists.
2. Audiologists.
3. Physicians.
4. Podiatrists.
5. Psychologists.
6. Certified Clinical Nurse Specialists.
7. Certified Nurse-Midwives.
8. Certified Nurse Practitioner.
9. Certified Registered Nurse Anesthetists.
10. Durable Medical Equipment Providers.
11. Naprapaths.
12. Home Infusion Therapy Providers.
13. Chiropractors.
14. Clinical Social Workers.
15. Clinical Professional Counselors.
16. Clinical Laboratories.
17. Marriage and Family Therapists.
18. Physical Therapists.

19. Occupational Therapists.
20. Speech Therapists.
21. Optometrists.
22. Orthotic Providers.
23. Prosthetic Providers.
24. Registered Dieticians.
25. Registered Surgical Assistants; or
26. Retail Health Clinics

who have signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Professional Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service—that is, your calendar year Deductible, Copayment and Coinsurance amounts.

Non-Participating Professional Providers are:

1. Acupuncturists.
2. Audiologists.
3. Physicians.
4. Podiatrists;
5. Psychologists.
6. Dentists.
7. Certified Clinical Nurse Specialists.
8. Certified Nurse-Midwives.
9. Certified Nurse Practitioner.
10. Certified Registered Nurse Anesthetists.
11. Durable Medical Equipment Providers.
12. Naprapaths.
13. Home Infusion Therapy Providers.
14. Chiropractors.
15. Clinical Social Workers.
16. Clinical Professional Counselors.
17. Clinical Laboratories.
18. Marriage and Family Therapists.
19. Physical Therapists.
20. Occupational Therapists.
21. Speech Therapists.
22. Optometrists.

23. Orthotic Providers.
24. Prosthetic Providers.
25. Registered Dieticians.
26. Registered Surgical Assistants.
27. Retail Health Clinics; or
28. other Professional Providers

who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Professional Provider, contact your Professional Provider or Blue Cross and Blue Shield.

Regarding the Schedule of Maximum Allowances, you should also understand the following:

1. If two or more surgical procedures are related or performed in the same operative area and are performed by the same or different Physician, Dentist or Podiatrist during the same operation, benefits will be provided only for the procedure which has the larger Maximum Allowance.
2. If two or more surgical procedures are related or are performed in the same operative area and are performed on different dates by the same or a different Physician, Dentist or Podiatrist, benefits will be based upon the procedure which has the largest Maximum Allowance and 50% of the Maximum Allowance for the procedure which has the next largest allowance.
3. Procedures performed for conditions resulting from the same accident or injury are considered related.
4. If a surgical procedure is repeated during an Inpatient stay, the benefit payment will be based upon 50% of the Maximum Allowance for such repeat procedure and only one such repeat will be considered a Covered Service.

PEDIATRIC VISION CARE

Your Physician coverage also includes benefits for Pediatric Vision Care. Benefits will be provided for Pediatric Vision Care services as described below.

This Blue Cross and Blue Shield vision care plan allows covered persons to select the Provider of their choice, Participating or Non-Participating. If you choose a Non-Participating Vision Provider, benefits will be reduced.

DEFINITIONS

Benefit Period - For purposes of Pediatric Vision Care, a period of time that begins on the later of 1) the covered person's effective date of coverage under this Policy, or 2) the last date a vision examination was performed on the covered person or that Vision Materials were provided to the covered person, whichever is applicable. (A Benefit Period does not coincide with a calendar year and may differ for each covered member.)

For purposes of Pediatric Vision Care, a licensed ophthalmologist or Optometrist operating within the scope of his or her license, or a dispensing optician operating within the scope of his or her license.

Participating Vision Provider - For purposes of this Pediatric Vision Care section, a Participating Vision Provider is a Provider that has a written agreement with the entity chosen by Blue Cross and Blue Shield to administer its pediatric vision care plan to provide pediatric vision care services to you at the time you receive the services.

Non-Participating Vision Provider - For purposes of this Pediatric Vision Care section, a Non-Participating Vision Provider is a Provider that has not entered into a written agreement with the entity chosen by Blue Cross and Blue Shield to administer its Pediatric Vision Care plan to provide pediatric vision care services to you at the time you receive the services.

Vision Materials - Corrective lenses and/or frames or contact lenses.

Eligibility

Children who are covered under this Policy, up to age 19, are eligible for benefits under this Pediatric Vision Care section.

Limitations and Exclusions

Pediatric Vision Care benefits do not include services or materials arising from:

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;
2. Aniseikonic spectacle lenses;
3. Medical and/or surgical treatment of the eye, eyes, or supporting structures;
4. Plano (non-prescription) lenses and/or contact lenses;
5. Non-prescription sunglasses (except for discount);
6. Services rendered after the date an insured person ceases to be covered under the policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order;
7. Services or materials provided by any other group benefit plan providing vision care;
8. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when Vision Materials would next become available;
9. Any vision service, treatment or materials not specifically listed as a covered service;
10. Services and materials that are Experimental/Investigational Services or materials which are rendered prior to your effective date;
11. Services and materials incurred after the termination date of your coverage unless otherwise indicated;
12. Services and materials not meeting accepted standards of optometric practice;

13. Services and materials resulting from your failure to comply with professionally prescribed treatment;
14. Telephone consultations;
15. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
16. Office injection control charges;
17. Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
18. State or territorial taxes on vision services performed;
19. Medical treatment of eye disease or injury;
20. Visual therapy;
21. Special lens designs or coatings other than those described;
22. Replacement of lost/stolen eyewear;
23. Two pairs of eyeglasses in lieu of bifocals;
24. Services not performed by licensed personnel;
25. Prosthetic devices and services;
26. Insurance of contact lenses;
27. Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption; and
28. Services covered under your medical/surgical plan.

How the Vision Care Plan Works

Under the vision care plan, you may visit any Provider and receive benefits for covered vision services and materials. In order to maximize benefits, however, you must purchase them from a Participating Vision Provider.

Before you go to a Participating Vision Provider for an eye examination, eyeglasses, or contact lenses, please call ahead for an appointment. When you arrive, show the receptionist your identification card. If you forget to take your card, be sure to say that you are a member of the Blue Cross and Blue Shield vision care plan so that your eligibility can be verified.

To locate a Participating Vision Provider, visit EyeMed Vision Care, LLC (EyeMed)'s website at *www.eyemed.com* and use the Find a Provider link (choose the Select network for your search), or call 1-844-684-2254.

Questions about services covered under the vision care plan, Participating Vision Providers, or about benefits provided or denied under the plan can be directed to EyeMed seven days a week, Monday through Saturday 6:30 a.m. to 10:00 p.m., and Sunday 10:00 a.m. to 7:00 p.m. (Central Time) at 1-844-684-2254. An Interactive Voice Response unit is also available outside normal business operating hours. (Please direct member enrollment, termination, and other subscriber or dependent eligibility questions to Blue Cross Blue Shield of Illinois - not to EyeMed.) Members using a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services through calling or using a TTY machine to engage an operator at 711 and asking the operator to call EyeMed at 1-844-230-6498. Customer service hours and operations are subject to change without notice.

If you obtain glasses or contacts from a Non-Participating Vision Provider, you must pay the Provider in full and submit a Claim for reimbursement (see *How To File a Claim* section for more information).

You may receive your eye examination and eyeglasses/contacts on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Provider. Continuity of care will best be maintained when all available services are obtained at one time from one Participating Vision Provider and there may be

additional professional charges if you seek contact lenses from a Provider other than the one who performed your eye examination.

Fees charged for services other than a covered vision examination or covered Vision Materials and amounts in excess of those payable under this Pediatric Vision Care program, must be paid in full by you to the Provider, whether or not the Provider participates in the vision care plan network. Benefits under this Pediatric Vision Care program may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

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 (1) 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 must be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

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

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

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

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

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 level as described for Inpatient Hospital Covered Services.

OTHER COVERED SERVICES

Benefits will be provided under this Policy for the following Other Covered Services:

1. The processing, transporting, storing, handling, and administration of blood and blood components.
2. **Private Duty Nursing Service**—Benefits for Private Duty Nursing Service will be provided to you as an Inpatient in a Hospital or other health care facility when it is determined that the services provided are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the Hospital or other health care facility. Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they could not be or are not usually provided by the regular nursing staff of the Hospital or other health care facility. Benefits will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family.
3. **Ambulance Transportation**—When your condition is such that an ambulance is Medically Necessary. Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation when rendered in connection with a covered Inpatient admission or covered Emergency Medical Care.
4. **Dental accident care**—Dental services rendered by a Dentist or Physician, which are required as the result of an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
5. **Allergy shots and allergy surveys.**
6. **Oxygen and its administration.**
7. **Medical and surgical dressings, supplies, casts and splints.**
8. **Naprapathic Service**—Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of 15 visits per Benefit Period.
9. **Hearing Implants**—Benefits will be provided for bone anchored Hearing Aids and (cochlear implants).
10. **Hearing Aid**—
    a. Benefits will be provided for Medically Necessary Hearing Aids when a Hearing Care Professional prescribes a Hearing Aid to augment communication as follows:
        i. One Hearing Aid will be covered for each ear every 24 months.
        ii. Related services, such as audiological examinations and selection, fitting, and adjustment of ear molds to maintain optimal fit will be covered when deemed Medically Necessary by a Hearing Care Professional; and
        iii. Hearing Aid repairs will be covered when deemed Medically Necessary.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

Benefits for Other Covered Services will be provided at the Other Covered Services payment level as shown on the Schedule Page of this Policy after you have met your calendar year Deductible 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 Policy for Hospital and Physician Covered Services.

Notwithstanding anything else described herein, Providers of Ambulance Transportation will be paid based on the Ambulance Transportation Eligible Charge. Benefits for Ambulance Transportation will be provided at the Other Covered

Services benefit payment level as shown on the Schedule Page of this Policy after you have met your calendar year Deductible.

After benefits for Other Covered Services have been paid under this Policy, you may be responsible to pay your Provider an amount up to the Billed Charges. When receiving benefits for Ambulance Transportation related to Emergency Accident Care or Emergency Medical Care, you will not be responsible for amounts other than those listed on the Schedule Page of this Policy.

Participating Professional Providers are:

1. Acupuncturists.
2. Audiologists.
3. Physicians.
4. Podiatrists.
5. Psychologists.
6. Certified Clinical Nurse Specialists.
7. Certified Nurse-Midwives.
8. Certified Nurse Practitioner.
9. Certified Registered Nurse Anesthetists.
10. Chiropractors.
11. Clinical Social Workers.
12. Clinical Professional Counselors.
13. Clinical Laboratories.
14. Durable Medical Equipment Providers.
15. Home Infusion Therapy Providers.
16. Marriage and Family Therapists.
17. Naprapaths;
18. Physical Therapists.
19. Occupational Therapists.
20. Speech Therapists.
21. Optometrists.
22. Orthotic Providers.
23. Prosthetic Providers.
24. Registered Dieticians.
25. Registered Surgical Assistants; and
26. Retail Health Clinics.

who have signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Participating Professional Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit

payment and the Maximum Allowance for the particular Covered Service—that is, your calendar year Deductible, Copayment and Coinsurance amounts.

Non-Participating Professional Providers are:

1. Acupuncturists.
2. Audiologists.
3. Physicians.
4. Podiatrists.
5. Psychologists.
6. Certified Clinical Nurse Specialists.
7. Certified Nurse-Midwives.
8. Certified Nurse Practitioner.
9. Certified Registered Nurse Anesthetists.
10. Chiropractors.
11. Clinical Social Workers.
12. Clinical Professional Counselors.
13. Clinical Laboratories.
14. Durable Medical Equipment Providers.
15. Home Infusion Therapy Providers.
16. Marriage and Family Therapists.
17. Naprapaths.
18. Physical Therapists.
19. Occupational Therapists.
20. Speech Therapists.
21. Optometrists.
22. Orthotic Providers.
23. Prosthetic Providers.
24. Registered Dieticians.
25. Registered Surgical Assistants.
26. Retail Health Clinics; and
27. other Professional Providers.

who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular procedure is a Covered Service, contact your Professional Provider or Blue Cross and Blue Shield.

SPECIAL CONDITIONS

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

HUMAN ORGAN TRANSPLANTS

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

1. If both the donor and recipient have Blue Cross and Blue Shield coverage each will have their benefits paid by their own Blue Cross and Blue Shield program.
2. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Policy will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Policy will be provided for you. However, no benefits will be provided for the recipient.

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

1. **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 by telephone before your transplant Surgery has been scheduled. Blue Cross and Blue Shield will furnish you with the names of Hospitals which have Plan approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Plan approved Human Organ Transplant Coverage Program.**
2. Your benefits under this coverage will begin no earlier than 5 days prior to the transplant Surgery and shall continue for a period of no longer than 365 days after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.
3. Benefits will also be provided for 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.
4. If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and one or two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

   Benefits for lodging will be provided at 100% of the Transplant Lodging Eligible Expense. Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.

In addition to the other Exclusions of this Policy, benefits will not be provided for the following:

1. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
2. Transportation by air ambulance for the donor or the recipient.
3. Travel time and related expenses required by a Provider.
4. Drugs which are Experimental/Investigational.
5. Drugs which do not have the approval of the Food and Drug Administration.

6. Storage fees.

7. Services provided to any individual who is not the recipient or actual donor, unless otherwise specified provision.

8. Meals.

CARDIAC REHABILITATION

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 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.

SKILLED NURSING FACILITY CARE

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

1. Bed, board and general nursing care.

2. Ancillary services (such as drugs and surgical dressings or supplies).

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

After you have met your calendar year Deductible, benefits will be provided at the Inpatient Hospital payment level for Participating Providers as shown on the Schedule Page of this Policy, for Covered Services rendered in a Participating Skilled Nursing Facility. For Covered Services rendered in a Non-Participating Skilled Nursing Facility, benefits will be provided at the Inpatient Hospital payment level for Non-Participating Providers specified on the Schedule Page of this Policy, after you have met your calendar year Deductible.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this Policy 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 the Participating Provider Freestanding Facility payment level specified in the Outpatient Surgical Covered Services section on the Schedule Page of this Policy. Benefits for services by a Non-Participating Ambulatory Surgical Facility will be provided at the Non-Participating Provider payment level specified in the Outpatient Surgical Covered Services section on the Schedule Page of this Policy.

Benefits for Outpatient Surgery will be provided as stated above after you have met your calendar year Deductible.

PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided for in this Policy, (and notwithstanding anything in this Policy to the contrary), the following benefits for preventive care services will be considered Covered Services and will not be subject to any Deductible, Coinsurance, Copayment or dollar (to be implemented in the quantities and within the time period allowed under applicable law or regulatory guidance) maximum when such services are received from a Participating Provider (to be implemented in the quantities and within the time period allowed under applicable law or regulatory guidance):

1. Evidence-based items or services that have in effect a rating of “A" or “B" in the current recommendations of the United States Preventive Services Task Force (“USPSTF");

2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC") with respect to the individual involved.

3. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA") for infants, children, and adolescents; and

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

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

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

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

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

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

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

1. Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked.
2. Aspirin use for men and women for prevention of cardiovascular disease for certain ages.
3. Blood pressure screening.
4. Cholesterol screening for adults of certain ages or at higher risk.
5. Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions.
6. Colorectal cancer screening for adults over age 45.
7. Depression screening.
8. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease.
9. HIV screening for all adults at higher risk.
10. HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition, including baseline and monitoring services.
11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    a. Diphtheria, Tetanus, Pertussis (DTap/Tdap/Td);
    b. Haemophilus influenzae type b (Hib);
    c. Hepatitis A;
    d. Hepatitis B;
    e. Herpes Zoster (Shingles);
    f. Human papillomavirus;

g. Influenza (Flu shot or Flu mist);

h. Measles, Mumps, Rubella;

i. Meningococcal;

j. MPOX;

k. Pneumococcal;

l. RSV;

m. Varicella; and

n. COVID-19.

12. Unhealthy alcohol and drug use screening and counseling.

13. Obesity screening and counseling.

14. Sexually transmitted infections (STI) counseling.

15. Tobacco use screening and cessation interventions for Tobacco Users.

16. Syphilis screening for adults at higher risk.

17. Exercise interventions to prevent falls in adults age 65 years and older who are at increased risk for falls;

18. Hepatitis C virus (HCV) screening for infection in adults aged 18 to 79 years.

19. Hepatitis B virus screening for persons at high risk for infection.

20. Counseling children, adolescents and young adults who have fair skin, about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

21. Whole body skin examination for lesions suspicious for skin cancer.

22. Mental health prevention and wellness.

23. Lung cancer screening in adults 50 and older who have a 20-pack per year smoking history and currently smoke or have quit within the past 15 years.

24. Screening for high blood pressure in adults age 18 years or older;

25. Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese.

26. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with:

    a. No history of CVD.

    b. 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking); and

    c. A calculated 10-year CVD risk of 10% or greater.

27. Tuberculin testing for adults 18 years or older who are at a higher risk of tuberculosis.

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

1. Bacteriuria urinary tract screening or other infection screening for pregnant persons;

2. BRCA counseling about genetic testing for women at higher risk and if recommended by a Provider after counseling, genetic testing.

3. Breast cancer chemoprevention counseling for women at higher risk.
4. Breastfeeding comprehensive lactation support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Electric breast pumps are limited to 1 per Benefit Period.
5. Cervical cancer screening.
6. Chlamydia infection screening for younger women and women at higher risk.
7. Contraception: Certain FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling.
8. Domestic and interpersonal violence screening and counseling for all women.
9. Daily supplements of .4 to .8 mg of folic acid for women who may become pregnant.
10. Diabetes screening after pregnancy.
11. Female and male condoms.
12. Gestational diabetes screening for women after 24 weeks pregnant and those at high risk of developing gestational diabetes.
13. Gonorrhea screening for all women.
14. Hepatitis B screening for pregnant persons at their first prenatal visit.
15. HIV screening and counseling.
16. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older.
17. Osteoporosis screening for women over age 65, and younger women with risk factors.
18. Perinatal depression screening and counseling.
19. Rh incompatibility screening for all pregnant persons and follow-up testing for women at higher risk.
20. Tobacco use screening and interventions for all women and expanded counseling for pregnant Tobacco Users.
21. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened.
22. Sexually transmitted infections (STI) counseling.
23. Syphilis screening for all persons women or other women at increased risk.
24. Well-woman visits to obtain recommended preventive services.
25. Urinary incontinence screening.
26. Breast cancer mammography screenings, including breast tomosynthesis and, if Medically Necessary, a screening MRI, and comprehensive ultrasound.
27. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal.
28. Aspirin use for persons women to prevent preeclampsia.
29. Screening for preeclampsia in persons women with blood pressure measurements throughout pregnancy.
30. Behavioral counseling to promote healthy weight gain during pregnancy.

31. Behavioral counseling to maintain weight or limit weight gain to prevent obesity for women who are aged 40 or older.
32. Menopause health visit.

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

1. Alcohol and drug use assessment for adolescents.
2. Behavioral assessments for children of all ages.
3. Blood pressure screenings for children of all ages.
4. Cervical dysplasia screening for females.
5. Congenital hypothyroidism screening for newborns.
6. Critical congenital heart defect screening for newborns.
7. Depression screening for adolescents.
8. Development screening for children under age 3, and surveillance throughout childhood.
9. Dyslipidemia screening for children ages 9-11 and 17-21.
10. Bilirubin screening in newborns.
11. Fluoride chemoprevention supplements for children without fluoride in their water source.
12. Fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.
13. Gonorrhea preventive medication for the eyes of all newborns.
14. Hearing screening for all newborns, children, and adolescents.
15. Height, weight and body mass index measurements.
16. Hematocrit or hemoglobin screening.
17. Hemoglobinopathies or sickle cell screening for all newborns.
18. HIV screening for adolescents at higher risk.
19. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    a. Diphtheria, Tetanus, Pertussis (DTap/Tdap/Td);
    b. Haemophilus influenzae type b (Hib);
    c. Hepatitis A;
    d. Hepatitis B;
    e. Herpes Zoster (Shingles);
    f. Human papillomavirus;
    g. Influenza (Flu shot or Flu mist);
    h. Measles, Mumps, Rubella;
    i. Meningococcal;
    j. MPOX;
    k. Pneumococcal;

l. RSV;

m. Varicella; and

n. COVID-19.

20. Lead screening for children at risk for exposure.
21. Autism screening for children at 18 and 24 months of age.
22. Medical history for all children throughout development.
23. Obesity screening and counseling.
24. Oral health risk assessment for younger children up to six years old.
25. Phenylketonuria (PKU) screening for newborns.
26. Sexually transmitted infections (STI) prevention and counseling for adolescents.
27. Tuberculin testing for children at higher risk of tuberculosis.
28. Vision screening for children and adolescents.
29. Tobacco use interventions, including education or counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
30. Newborn blood screening.
31. Whole body skin examination for lesions suspicious for skin cancer.
32. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a non-Participating Pharmacy may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximum, if applicable.

A $0 copay waiver can be requested for alternative formulations or non-preferred drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List. Please call the Customer Service telephone number on the back of your identification card for more information, or visit *www.bcbsil.com/provider* or *www.myprime.com* to obtain a copay waiver form.

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

Benefits are not available under this benefit provision for Contraceptive drugs and devices not listed on the Contraceptive Coverage List. You may, however, have coverage under other sections of this Policy, subject to any applicable Coinsurance, Copayments, Deductibles and/or benefit maximum. The Contraceptive Coverage List and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

Pediatric care, women's preventive care (such as contraceptives) and/or Outpatient periodic health examinations Covered Services not included above will be subject to the Deductible, Coinsurance, Copayments and/or benefit maximums previously described in this Policy, if applicable.

Preventive care services received from a Non-Participating Provider or a Non-Participating Pharmacy, or other routine Covered Services may be subject to the Deductible, Coinsurance, Copayments and/or benefit maximum.

Benefits for vaccinations that are considered preventive care services will not be subject to any Deductible, Coinsurance, Copayment, or dollar maximum when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service.

Vaccinations that are received from a Non-Participating Provider or a Non-Participating Pharmacy, or other routine Covered Services may be subject to the Deductible, Coinsurance, Copayments and/or benefit maximums.

Mental Illness and Substance Use Disorder Services

Benefits for all of the Covered Services described in this Policy are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Benefits for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder includes pregnancy and postpartum periods and are available for those who have experienced a miscarriage or stillbirth. Medical Care for the 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. Mental Illness and Substance Use Disorder Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield will be paid at the Non-Participating Provider facility payment level.

Note: Benefits will be provided at no charge for an annual mental health prevention and wellness visit when obtained from a Participating Provider.

Substance Use Disorder Treatment

Benefits for all of the Covered Services previously described in this Policy are available for Substance Use Disorder 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 Treatment in a Residential Treatment Center. Substance Use Disorder Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield will be paid at the Non-Participating Provider facility payment level.

Detoxification

Benefits for Covered Services received for detoxification will be provided under the *Hospital Benefits* and *Physician Benefits* sections of this Policy, the same as any other condition.

Bariatric Surgery

Benefits for Covered Services received for Bariatric Surgery will be provided under the *Hospital Benefits* and *Physician Benefits* sections of this Policy, the same as any other condition.

AUTISM SPECTRUM DISORDER(S)

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) a Physician or a Psychologist who has determined that such care is Medically Necessary, or (b) a certified, registered or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) including but not limited to a health care professional who is eligible as Qualified ABA Provider by state regulation and when such care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:

1. Psychiatric care, including Diagnostic Services.
2. Psychological assessments and treatments.
3. Habilitative or rehabilitative treatments.
4. Therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

Prior Authorization will assess whether services meet coverage requirements. Review the "Outpatient Service Prior Authorization Review" provision of the *Blue Cross and Blue Shield Behavioral Health Unit* section of this Policy for more specific information about Prior Authorization.

HABILITATIVE SERVICES

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

1. A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
2. Treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and
3. Treatment must be Medically Necessary and therapeutic and not Experimental/Investigational.

Early Treatment of a Serious Mental Illness

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

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

In addition to the *Definitions* in this Policy, the following *Definitions* are applicable to this provision:

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

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

MAMMOGRAMS

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

1. One baseline mammogram and
2. An annual mammogram.

Benefits for routine mammograms will be provided for those who have a family history of breast cancer or other risk factors at the age and intervals considered Medically Necessary by their Physician.

If a routine mammogram reveals heterogeneous or dense breast tissue, or when determined to be Medically Necessary by a Physician, Advanced Practice Nurse, or Physician Assistant, benefits will be provided for a comprehensive ultrasound

screening, molecular breast imaging (MBI) and magnetic resonance imaging ("MRI") screening of an entire breast or breasts.

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

Benefits for mammograms will be provided at 100% of the Eligible Charge, or Maximum Allowance, whether or not you have met your program Deductible.

In addition to the *Definitions Section* of this Policy the following definitions are applicable to this provision:

Diagnostic Mammogram – means a mammogram obtained using Diagnostic Mammography.

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

COMPLICATIONS OF PREGNANCY

Benefits will be provided under this Policy for Covered Services received in connection with Complications of Pregnancy.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife, a certified professional midwife, a perinatal doula or a certified lactation consultant. Covered services include home births (including necessary equipment and supplies), home visits, and support during labor, abortion, or miscarriage.

NOTE: Home visits by a perinatal doula may be limited to sixteen (16) visits before birth, and sixteen (16) visits after birth.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are:

a) the routine Inpatient Hospital nursery charges.

b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and.

c) one Inpatient hearing screening.

(If the newborn child needs treatment for an illness, injury, congenital defect including Medically Necessary treatment and care for cleft lip and palate), birth abnormality or a premature birth, benefits will be available for that care from the moment of birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage. You may apply for Family Coverage within 31 days of the date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any Hospital length of stay in connection with childbirth for the 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 for prescribing a length of stay less than 48 hours (or 96 hours).

OTHER REPRODUCTIVE HEALTH SERVICES

Your coverage includes benefits for abortion care. Benefits for abortion care will be provided at no cost after your program deductible has been met under this Hospital Benefits Section, if applicable.

INFERTILITY TREATMENT

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, uterine embryo lavage,

embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means a disease, condition, or status characterized by:

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

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

Benefits for treatments that include oocyte retrievals will be provided only when you have been unable to attain or maintain a viable pregnancy or sustain a successful pregnancy through reasonable, less costly, medically appropriate Infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless. Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per Benefit Period, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered per Benefit Period.

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

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

Special Limitations

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

1. 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.
2. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance. Please note, that benefits may be provided for fertility preservation as set forth in the "Fertility Preservation Services" provision of this Policy below.
3. Non-medical costs of an egg or sperm donor.
4. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield.
5. Infertility treatments which are deemed Experimental/Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

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.

FERTILITY PRESERVATION SERVICES

Benefits will be provided for Medically Necessary Standard Fertility Preservation services when a necessary medical treatment May Directly or Indirectly Cause Iatrogenic Infertility to a covered person.

HUMAN BREAST MILK COVERAGE

Benefits for pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed medical practitioner, will be provided for a covered infant under the age of 6 months, if the following conditions have been met:

1. The milk is prescribed by a licensed medical practitioner.
2. The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
3. The infant's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
4. The milk has been determined to be Medically Necessary for the infant; and
5. One or more of the following applies:
    a. The infant's birth weight is below 1,500 grams.
    b. The infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
    c. The infant has infant hypoglycemia.
    d. The infant has congenital heart disease.
    e. The infant has had or will have an organ transplant.
    f. The infant has sepsis; or
    g. The infant has any other serious congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the infant.

Benefits for pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed medical practitioner, will be provided for a covered child between 6-12 months of age, if the following conditions have been met:

1. The milk is prescribed by a licensed medical practitioner.
2. The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
3. The infant's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
4. The milk has been determined to be Medically Necessary for the infant; and
5. One or more of the following applies:
    a. The child has spinal muscular atrophy.
    b. The child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity.
    c. The child has had or will have an organ transplant; or
    d. The child has a congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the child.

For more information about this benefit, you may visit our website at *www.bcbsil.com* or call customer service at the number on the back of your identification card.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) post mastectomy care for inpatient treatment for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within forty-eight (48) hours after discharge; and 4) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; are the same as for any other condition.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

PORT WINE STAIN TREATMENT

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

VIRTUAL VISITS

Benefits will be provided for Covered Services described in this Policy for the diagnosis and treatment of non-emergency medical and behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit.

Benefits for such Covered Services will only be provided if you receive them via consultation with a Virtual Provider who has a specific written agreement with Blue Cross and Blue Shield to provide Virtual Visits to you at the time services are rendered. For more information about this benefit, you may visit our website at *www.bcbsil.com* or call customer service at the number on the back of your identification card.

Benefits for Covered Services you receive during a Virtual Visit will be provided at the payment level shown on the Schedule Page of this Policy. Benefits will not be provided for services you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with Blue Cross and Blue Shield to provide Virtual Visits.

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

OUTPATIENT PRESCRIPTION DRUG PROGRAM

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

Although you can go to the Pharmacy of your choice, your benefits for drugs and supplies will be greater when you obtain them from a Preferred Participating Pharmacy. You can visit the Blue Cross and Blue Shield website at *www.bcbsil.com* for a list of Preferred Participating Pharmacies or Pharmacies participating in Pharmacy Match Program or call the customer service toll-free number on your identification card. Preferred Participating Pharmacies, Participating Pharmacies, Pharmacies participating in Pharmacy Match Program may change. You should check with your Pharmacy before obtaining drugs or supplies to make certain of its participation status. The benefits of this section are subject to all of the terms and conditions of this Policy. Please refer to the *Definitions*, *Coverage* and *Premium Information, and Exclusions – What is Not Covered* sections of this Policy for additional information regarding any limitations and/or special conditions pertaining to your benefits.

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

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

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

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

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

COPAYMENT AMOUNT – means the dollar amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

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

1. Which is Medically Necessary and is ordered by a Health Care Practitioner naming you as the recipient.
2. For which a written or verbal Prescription Order is provided by a Health Care Practitioner.
3. For which a separate charge is customarily made.
4. Which is not consumed or administered at the time and place that the Prescription Order is written.
5. For which the FDA has given approval for at least one indication; and
6. Which is dispensed by a Pharmacy and is received by you while covered under this benefit section, except when received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the "Exclusions**"** provision later in this benefit section).

DRUG LIST – means a list of all drugs that may be covered under the *Outpatient Prescription Drug Program Benefit* section of this Policy. A current list is available on our website at *https://www.bcbsil.com/rx-drugs/drug-lists/drug-lists*. You may also contact a customer service representative at the telephone number shown on the back of your identification card for more information.

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

1. The charge which the particular Pharmacy usually charges for Covered Services; or
2. The agreed upon cost between a Participating Pharmacy and a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, whichever is lower.

GENERIC DRUG – means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs, Blue Cross and Blue Shield utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information. Generic Drugs are listed on the *Drug List* which is available on the Blue Cross and Blue Shield website at *www.bcbsil.com*. You may also contact a customer service advocate for more information.

HEALTH CARE PRACTITIONER – means an Advanced Practice Nurse, Doctor of Medicine, Doctor of Dentistry, Physician Assistant, Doctor of Osteopathy, Doctor of Podiatry, or other licensed person with prescription authority.

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

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

NON-PARTICIPATING PHARMACY OR NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER.....has the meaning set forth in the *Definitions Section* of this Policy.

NON-PREFERRED BRAND NAME DRUG – means a Brand Name Drug that is identified on the *Drug List* as a Non-Preferred Brand Name Drug. The *Drug List* is available by accessing the Blue Cross and Blue Shield website at *www.bcbsil.com*.

NON-PREFERRED GENERIC DRUG – means a Generic Drug that is identified on the *Drug List* as a Non-Preferred Generic Drug. The *Drug List* is available by accessing the Blue Cross and Blue Shield website at *www.bcbsil.com*.

PARTICIPATING PHARMACY OR PARTICIPATING PRESCRIPTION DRUG PROVIDER – has the meaning set forth in the Definitions Section of this Policy.

PHARMACY – has the meaning set forth in the Definitions Section of this Policy.

PREFERRED BRAND NAME DRUG – means a Brand Name Drug that is identified on the Drug List as a Preferred Brand Name Drug. The Drug List is available by accessing the Blue Cross and Blue Shield website at *www.bcbsil.com*.

PREFERRED GENERIC DRUG – means a Generic Drug that is identified on the Drug List as a Preferred Generic Drug. The Drug List is available by accessing the Blue Cross and Blue Shield website at *www.bcbsil.com*.

PREFERRED PARTICIPATING PHARMACY – means a Participating Pharmacy which has a written agreement with Blue Cross and Blue Shield to provide pharmaceutical services to you or an entity chosen by Blue Cross and Blue Shield to administer its prescription drug program that has been designated as a Preferred Participating Pharmacy.

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

SPECIALTY DRUGS – means prescription drugs that:

(1) is prescribed for a person with a complex or chronic medical condition or a rare medical condition;

(2) has limited or exclusive distribution; and

(3) requires both:

(A) specialized product handling by the dispensing pharmacy or administration by the dispensing pharmacy; and

(B) specialized clinical care, including frequent dosing adjustments, intensive clinical monitoring, or expanded services for patients, including intensive patient counseling, education, or ongoing clinical support beyond traditional dispensing activities, such as individualized disease and therapy management to support improved health outcomes.

ABOUT YOUR BENEFITS

Drug List

Drugs listed on the Drug List are selected by Blue Cross and Blue Shield based upon the recommendations of a committee, which is made up of current and previously practicing physicians and pharmacists from across the country, some of whom are employed by or affiliated with Blue Cross and Blue Shield. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the Drug List. Entire drug classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List.

Positive changes (e.g., adding drugs to the Drug List or drugs moving to a lower payment tier) occur quarterly after review by the committee. Changes to the Drug List that could have an adverse financial impact to you (i.e., drug exclusion, drug moving to a higher payment tier, or drugs requiring prior authorization) occur quarterly or annually. However, when there has been a pharmaceutical manufacturer recall or other safety concern, changes to the Drug List may occur more frequently.

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

Your prescribing health care Provider (your “prescriber”), or your authorized representative, can ask for the *Drug List* exception if your drug is not on (or is being removed from) the *Drug List* or the drug is required as part of the dispensing limit has been found to be (or is likely to be) not right for you or does not work as well in treating your condition. To request this exception, you, your prescriber, or your authorized representative, can call the number on the back of your identification card to ask for a review. Blue Cross and Blue Shield will let you, your prescriber, or authorized representative know the coverage decision within 72 hours after they receive your request. If the coverage request is denied, Blue Cross and Blue Shield will let you, your prescriber, or your authorized representative know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals and external exception review process you will receive with the denial determination.

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

Prior Authorization Requirement

When certain medications and drug classes, such as medications used to treat rheumatoid arthritis, growth hormone deficiency, and hepatitis C are prescribed, your Physician will be required to obtain authorization from Blue Cross and Blue Shield. Medications included in this program are subject to change and other medications for other conditions may be added to the program. Although you may currently be on therapy, your Claim may need to be reviewed to see if the criteria for coverage of further treatment have been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the brand name medication.

Blue Cross and Blue Shield's prescription drug administrator will send a questionnaire to your Physician upon your or your Pharmacy's request. The questionnaire must be returned to the prescription drug administrator who will review the questionnaire and determine whether the reason for the prescription meets the criteria for Medically Necessary care. You and your Physician will be notified of the prescription drug administrator's determination. Coverage will only be provided for Medically Necessary care. Although you are not required to obtain authorization prior to purchasing the medication, you are strongly encouraged to do so, to help you and your doctor factor your cost into your treatment decision. If criteria for Medical Necessity is not met, coverage will be denied, and you will be responsible for the full charge incurred.

To find out more about prior authorization requirements or to determine which drugs or drug classes require prior authorization, you should refer to the *Drug List* by accessing the Blue Cross and Blue Shield website at *www.bcbsil.com* or call the customer service toll-free number on your identification card. Please see the "*Drug List*" provision for more information about changes to the programs.

Controlled Substances Limitation

If it is determined that you may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary and appropriate and coverage restrictions, which may include but not limited to limiting coverage to services provided by a certain Provider and/or Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. For the purpose of this provision, controlled substance medications are medications classified or restricted by state or federal laws. Additional Coinsurance Amount and/or Copayment Amount and any Deductible may apply.

Day Supply

In order to be eligible for coverage under this benefit section, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation described in this benefit section. Benefits under this benefit section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Coverage for certain Covered Drugs are limited to a 30-day supply. However, some Covered Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply, if allowed by your plan benefits. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed. For information about benefits for these drugs call the customer service toll-free telephone number located on your identification card. However, early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the Physician or Optometrist. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained. However, you may receive coverage for up to a 12-month supply for dispensed contraceptive drugs and products that are covered under this benefit section. For additional information about early refills, please see the Prescription Refills provision below.

Multi-Category Split Fill Program

If this is your first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders etc.) or a medication that has not been filled within 120 days, the Member may only be eligible for a partial fill (14-15-day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. If you receive a partial fill, your cost-share may be adjusted to align with the number of pills dispensed. If the medication is working for you and your Physician wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit the *https://www.bcbsil.com/rx-drugs/pharmacy/programs-other-members* program website. Please be advised these lists are subject to change without notice.

GLP-1 30-Day Supply Maximum

Coverage is limited to a 30-day supply per fill, for GLP-1 medications.

Prescription Refills

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

1. The prescription drugs are covered under this Policy or have received an exception approval as described under the *Drug List* provision above.
2. The prescription drugs are maintenance medications and have refill quantities available to be refilled at the time of synchronization.
3. The medications are not Schedule II, III, or IV controlled substances as defined in the Illinois Controlled Substances Act.
4. All utilization management criteria (as described under the “Prior Authorization Requirement” provision above) for prescription drugs have been met.
5. The prescription drugs can be safely split into short-fill periods to achieve synchronization; and
6. The prescription drugs do not have special handling or sourcing needs that require a single, designated Pharmacy to fill or refill the Prescription Order.

When necessary to permit synchronization, Blue Cross and Blue Shield will prorate the Copayment Amount or Coinsurance Amount, on a daily basis, due for Covered Drugs based on the proportion of days the reduced Prescription Order covers to the regular day supply as shown on the Schedule Page in this Policy.

Extended Prescription Drug Supply Program

Your coverage includes benefits up to a 90-day supply of covered maintenance type drugs and diabetic supplies purchased from a Preferred Participating Pharmacy (which may only include retail or home delivery pharmacies). However, you may receive coverage for up to a 12-month supply for dispensed contraceptive drugs and products that are covered under the Outpatient Prescription Drug Program benefit section. Benefit payment amounts listed on the Schedule Page of this Policy are for a 30-day supply. To find a list of Pharmacies participating in this program, refer to the Blue Cross and Blue Shield website at *www.bcbsil.com*.

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

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

Dispensing Limits

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, coverage will only be provided for a clinically appropriate pre-determined maximum quantity of medication for

the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

The maximum quantity of a given prescription drug means the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. However, benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained. To determine if a specific drug is subject to this limitation, you can refer to the *Drug List* by accessing the Blue Cross and Blue Shield website at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

If you require a Prescription Order in excess of the dispensing limit established by Blue Cross and Blue Shield, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. Blue Cross and Blue Shield has the right to determine dispensing limits and they may change from time to time. Payment for benefits covered under this benefit section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

COVERED SERVICES

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

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

Some prescription drug products may be more cost-effective than others. In some instances, you and your Physician may be contacted by your Pharmacy about switching to an alternative drug. The Pharmacy may not provide a substitute drug without your Physician's and your approval. Please refer to the provision entitled "Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers" in the *General Provisions* section of this Policy.

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

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

Injectable Drugs

Benefits are available for Medically Necessary injectable administered drugs which are self-administered that require a written prescription by federal law, including but not limited to epinephrine injectors. Benefits will not be provided under this benefit section for any self-administered drugs dispensed by a Physician. Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.

Blood Glucose Monitors for Treatment of Diabetes

This plan provides benefits for Medically Necessary blood glucose monitors and related supplies (including continuous glucose monitors, non-invasive monitors, and monitors for the blind), if a Physician has provided a written order. Benefits for glucose monitors will be provided at no charge when obtained from a Participating Pharmacy after your program deductible has been met, if applicable.

Diabetic Supplies for Treatment of Diabetes

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

1. Test strips specified for use with a corresponding blood glucose monitor.
2. Glucose test solutions.

3. Glucagon.
4. Glucose tablets.
5. Lancets and lancet devices.
6. Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein.
7. Insulin and insulin analog preparations.
8. Injection aids, including devices used to assist with insulin injection and needleless systems.
9. Insulin syringes.
10. Biohazard disposable containers.
11. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels.
12. Glucagon emergency kits.

Abortifacients

Benefits will be provided at no charge for FDA-approved abortifacients, including FDA-approved drugs prescribed for off-label use and follow-up services, when obtained from a Participating Provider, after your program Deductible has been met.

Hormonal Therapy for Gender Dysphoria

Benefits will be provided at no charge for FDA-approved hormonal therapy medication for the treatment of gender dysphoria, including FDA-approved drugs prescribed for off-label use, when obtained from a Participating Pharmacy, and for follow-up services, when obtained from a Participating Provider, after your program Deductible has been met.

HIV Post-Exposure Prophylaxis

Benefits will be provided at no charge for FDA-approved HIV post-exposure prophylaxis drugs, including FDA-approved drugs prescribed for off-label use, when obtained from a Participating Pharmacy, and for follow-up services, when obtained from a Participating Provider, after your program Deductible has been met.

Vaccinations obtained through Participating Pharmacies

Benefits for vaccinations are available through certain Participating Pharmacies that have contracted with Blue Cross and Blue Shield to provide this service. To locate one of these contracting Participating Pharmacies in your area and to find out which vaccinations are covered, call the customer service toll-free number on your identification card. At the time you receive services, present your Blue Cross and Blue Shield identification card to the pharmacist. This will identify you as a participant in the Blue Cross and Blue Shield health care plan. The pharmacist will inform you of the amount for which you are responsible for, if any.

Each Participating Pharmacy that has contracted with Blue Cross and Blue Shield to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this benefit section. Refer to your Blue Cross and Blue Shield medical coverage for benefits available for childhood immunizations.

Benefits for select vaccinations that are considered preventive care services will not be subject to any Deductible, Coinsurance Amount, Copayment Amount or dollar maximum when such services are received from a Participating Provider or Participating Pharmacy that has contracted for such service.

Vaccinations that are received from a Non-Participating Provider or Non-Participating Pharmacy, and other routine Covered Services not provided for under this provision may be subject to the Deductible, Coinsurance Amount, Copayments Amount and/or benefit maximums.

Specialty Drugs

Benefits are available for Specialty Drugs as described under Pharmacy Match Program.

Prescription Inhalers

This plan provides benefits for Medically Necessary prescribed inhalers for those with asthma or other life-threatening bronchial ailments. Cost sharing for this coverage will not exceed $25 per 30-day supply, when obtained from a Participating Pharmacy.

Immunosuppressant Drugs

Benefits are available for immunosuppressive drugs prescribed in connection with a human organ transplant.

Fertility Drugs

Benefits are available for Medically Necessary fertility drugs in connection with the diagnosis and/or treatment of Infertility with a written prescription.

Contraceptive Drugs

Benefits are available under this benefit section for contraceptive drugs and products shown on the Contraceptive Coverage List. You may access the Blue Cross and Blue Shield website at *www.bcbsil.com* for more information.

Benefits for contraceptive drugs covered under this benefit section will not be subject to any Deductible, Coinsurance Amount and/or Copayment Amount when such services are received from a Participating Pharmacy Provider.

Self-Administered Cancer Medications

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

Benefits will be provided for orally administered cancer medications, or self-injected cancer medications that are used to treat cancer when a particular legend drug has been shown effective for the treatment of that specific type of cancer and if proper documentation is provided, even though that legend drug may not have FDA-approval for that type of cancer. The drug must have been shown to be effective for the treatment of that particular cancer according to the American Hospital Formulary Service Drug Information; National Comprehensive Cancer Network's Drugs & Biologics Compendium; Thomson Micromedex's Drug Dex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services. Your Deductible, Copayment Amount or Coinsurance Amount will not apply to orally administered cancer medications when received from a Participating Pharmacy. Coverage of prescribed orally administered cancer medications when received from Non-Participating Pharmacy Provider will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

Opioid Antagonists

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

Note: Benefits for naloxone hydrochloride, will be provided at no charge, when obtained from a Participating Pharmacy after your program Deductible has been met.

Opioid Medically Assisted Treatment

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

Intranasal Opioid Reversal Agent

Benefits will be provided for at least one intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50MME or higher.

Note: Benefits for naloxone hydrochloride, will be provided at no charge, when obtained from a Participating Pharmacy, after your program Deductible has been met.

Topical Anti-Inflammatory Acute and Chronic Pain Medication

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

Long-term Antibiotic Therapy

Benefits will be provided for Long-term Antibiotic Therapy, for a person with a Tick-Borne Disease, when determined to be Medically Necessary and ordered by a Physician after making a thorough evaluation of the patient’s symptoms, diagnostic test results, or response to treatment.

Oral antibiotics will be covered under this *Outpatient Prescription Drug Program Benefit* section. The member payment is indicated under the “Benefit Payment for Prescription Drugs” provision of this Policy.

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

Therapies to Treat Menopause

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

Vaginal Estrogen

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

Pregnancy Tests

Benefits will be provided for up to two (2) pregnancy tests every thirty (30) days, when prescribed for at-home use.

Prenatal Vitamins

Benefits will be provided for prenatal vitamins, when prescribed by a Physician or Advanced Practice Nurse.

SELECTING A PHARMACY

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

Participating Pharmacy

When you choose to go to a Participating Pharmacy:

1. Present your identification card to the pharmacist along with your Prescription Order.
2. Provide the pharmacist with the birth date and relationship of the patient.
3. Pay the applicable Deductible, if any; and
4. Pay the appropriate Copayment or Coinsurance Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

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

1. The Billed Charges; or
2. The Eligible Charge; or
3. The amount for which you are responsible for as described under the “Benefit Payment for Prescription Drugs” provision later in this benefit section.

The level of benefits paid will be the highest available under this Policy when pharmaceutical services are received from a Preferred Participating Pharmacy Provider.

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

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access the Blue Cross and Blue Shield website at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

Non-Participating Pharmacy

If you choose to have a Prescription Order filled or obtain a covered vaccination at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a Claim form to Blue Cross and Blue Shield or to the prescription drug administrator with itemized receipts verifying that the Prescription Order was filled, or a covered vaccination was provided.

Please refer to the provision entitled "Filing Outpatient Prescription Drug Claims" in the *How To File a Claim* section of this Policy.

Home Delivery Prescription Drug Program

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

Some drugs may not be available through the Home Delivery Prescription Drug Program. For a listing of Maintenance Drugs or if you have any questions about the Home Delivery Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the home delivery order form, you may access the Blue Cross and Blue Shield website at *www.bcbsil.com* or call the customer service toll-free number on your identification card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

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

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

For information about the Home Delivery Prescription Drug Program, call the customer service toll-free number on your identification card.

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

Pharmacy Match Program

For Covered Drugs identified on the "Pharmacy Match Drug List," generally Covered Drugs included within Tier 4 of your covered benefit, a Participating Pharmacy will be selected from a network of Participating Pharmacies contracted to participate in this program, to provide delivery of medications directly to your Health Care Practitioner, administration location, or to your home. Selection will include criteria such as the complexity of the prescription drug, the capabilities of and services provided by the pharmacy, and cost. If you do not wish to utilize the selected Participating Pharmacy, you may request use of the Participating Pharmacy of your choice. When you obtain the Covered Drug from a Participating Pharmacy, benefits will be provided according to the payment provisions indicated in the Policy. You should refer to the Prescription Drug Section on the Plan's website at www.bcbsil.com or call the customer service toll-free number on your identification card to identify which Covered Drugs are identified on the Pharmacy Match Drug List.

MedsYourWay™

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

The amount you pay for your Prescription will be applied, if applicable, to your Deductible and out-of-pocket maximum. Available select Covered Drugs and drug discount card pricing through MedsYourWay may change occasionally but your cost with available select covered drugs through MedsYourWay will never be higher than the listed cost share on the schedule for the specific tier the drug is listed under. Certain restrictions may apply, and certain Covered Drugs or drug discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount

for select Covered Drugs depending upon which retail pharmacy is utilized. For additional information regarding MedsYourWay, please contact a Customer Service Representative at the toll-free telephone number on the back of your Identification Card. Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting your Customer Service Representative at the toll-free telephone number on the back of your Identification Card.

YOUR COST

Deductible

If you are responsible for a Coinsurance, each Benefit Period you must satisfy the Participating Provider program Deductible described on the Schedule Page of this Policy for your medical benefits before your benefits will begin for drugs and diabetic supplies. If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in Out-of-Pocket expenses made by or on your behalf, that amount will be applied to your program Deductible or Out-of-Pocket expense limit.

If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in Out-of-Pocket expenses made by or on your behalf, that amount will not be applied to your program deductible or Out-of-Pocket expense limit until you have met the minimum annual deductible for HDHP-HSA plans, pursuant to federal law. Once this deductible has been met, then third-party payments, financial assistance, discount product voucher, or other reduction in Out-of-Pocket expenses made by or on your behalf will apply to any remaining Out-of-Pocket expense limit.

Expenses incurred by you for Covered Drugs and diabetic supplies received from a Preferred Participating Pharmacy, Participating Pharmacy will be applied towards the Participating Provider Deductible as indicated on the Schedule Page of this Policy.

Out-of-Pocket Expense Limit

Expenses incurred by you for Covered Drugs and diabetic supplies received from a Preferred Participating Pharmacy, or Participating Pharmacy will be applied towards the Participating Provider Out-of-Pocket expense limit as indicated on the Schedule Page of this Policy.

Expenses incurred by you for Covered Drugs and diabetic supplies received from a Non-Participating Pharmacy will be applied towards the Non-Participating Provider Out-of-Pocket expense limit as indicated on the Schedule Page of this Policy. When there is no Out-of-Pocket expense limit for Non-Participating Pharmacies as set forth in the Schedule Page of this Policy, you will continue to be responsible for any Deductible, Coinsurance Amount and/or Copayment Amount for Covered Drugs received from Non-Participating Pharmacies. If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in Out-of-Pocket expenses made by or on your behalf, that amount will be applied to your program deductible or Out-of-Pocket expense limit.

If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in Out-of-Pocket expenses made by or on your behalf, that amount will not be applied to your program Deductible or Out-of-Pocket expense limit until you have met the minimum annual deductible for HDHP-HSA plans, pursuant to federal law. Once this deductible has been met, then third-party payments, financial assistance, discount product voucher, or other reduction in Out-of-Pocket expenses made by or on your behalf will apply to any remaining Out-of-Pocket expense limit

BENEFIT PAYMENT FOR PRESCRIPTION DRUGS

How Member Payment is Determined

The amount that you are responsible for is based upon the drug tiers as described below and shown on the Schedule Page of this Policy.

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

- Tier 4 – includes Specialty Drugs, Preferred and Non-Preferred Brand Name Drugs and may contain some Generic Drugs.

If you or your Provider request a brand name drug when a generic drug is available, you will pay the applicable Copayment Amount and/or Coinsurance based on current tier of brand name drug plus the difference between the allowable amount of the brand name drug and the allowable amount of the generic drug, except as otherwise provided in the policy.

You may not be required to pay the difference in cost between the Allowable Amount of the Brand Name Drug and the Allowable Amount of the Generic Drug if there is a medical reason (e.g., adverse event) you need to take the Brand Name Drug and certain criteria are met. Your Provider can submit a request to waive the difference in cost between the Allowable Amount of the Brand Name Drug and Allowable Amount of the Generic Drug.

Any “differences” between the cost of the Generic Drug and the cost of the Brand Name Drug will apply to the Deductible or Out-of-Pocket maximum.

NOTE: Coverage will be available for a Brand Name Drug, if a generic drug or therapeutic equivalent is listed as currently in shortage or as a discontinuation in the FDA drug shortages database.

Retail Pharmacy

The benefits you receive and the amount you pay will differ depending upon the tier and type of drugs, or diabetic supplies or insulin and insulin syringes obtained and whether they are obtained from a Preferred Participating Pharmacy, Participating Pharmacy, or Non-Participating Pharmacy.

When you obtain Covered Drugs, including diabetic supplies from a Preferred Participating Pharmacy, Participating Pharmacy, or Pharmacy participating in Pharmacy Match Program benefits will be provided as shown on the Schedule Page of this Policy.

When you obtain Covered Drugs, including diabetic supplies from a Non-Participating Pharmacy (other than a Participating Pharmacy), benefits will be provided at 50% of the amount you would have received had you obtained drugs from a Participating Pharmacy Provider, minus the Deductible, if any. If an Out-of-Pocket expense limit is shown on the Schedule Page of this Policy for Non-Participating Pharmacy Providers, then the Copayment Amount and Coinsurance Amount will apply towards the Out-of-Pocket expense limit, if any, for Non-Participating Pharmacy Providers. However, none of your other expenses at such Non-Participating Pharmacy will apply towards the Out-of-Pocket expense limit.

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

One prescription means up to a 30-consecutive day supply of a drug. Coverage for certain drugs may be limited to less than a 30-consecutive day supply.

In addition, up to a 90-day supply of certain drugs may be obtained through the Extended Prescription Drug Supply Program.

However, you may receive coverage for up to a 12-month supply for oral contraceptives.

For additional information on these drugs, call the customer service toll-free number located on your identification card.

Home Delivery Prescription Drug Program

When you obtain Covered Drugs through the Home Delivery Prescription Drug Program, benefits will be provided as shown on the Schedule Page of this Policy.

Under the Home Delivery Prescription Drug Program, one prescription means up to a 90 consecutive day supply of a drug. Coverage for certain drugs may be limited to less than a 90 consecutive day supply.

However, you may receive coverage for up to a 12-month supply for dispensed contraceptives.

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

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

EXCLUSIONS

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

1. Administration or injection of any drugs; select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.
2. Any portion of Covered Services or Covered Drugs paid for through Prohibited Third-Party Cost Sharing Payments.
3. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Vaccinations administered through certain Participating Pharmacies are an exception to this exclusion.
4. Athletic performance enhancement drugs.
5. Benefits will not be provided for any self-administered drugs under this benefit section dispensed by a Physician.
6. Bulk Powders.
7. Certain drug classes where there are over-the-counter alternatives available.
8. Compound Drugs.
9. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
10. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper Claim be, provided under the Workers' Compensation law.
11. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies). However, coverage for prescription contraceptive devices and the rental or purchase of a manual electric or Hospital grade breast pump may be provided under the medical portion ("Preventive Care Services" provision) of this Policy.
12. Devices, "Technologies, and/or" Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, therapeutic devices, artificial appliance, "digital health technologies and/or applications," or similar devices (except disposable hypodermic needles and syringes for self-administered injections).
13. Diagnostic agents (except for diabetic testing supplies or test strips).
14. Drugs determined to have inferior efficacy or significant safety issues.
15. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
16. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this benefit section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed in excess of the amount or beyond the time period allowed by law.
17. Drugs obtained by unauthorized, fraudulent, abusive or improper use of the identification card.
18. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.

19. Drugs"/Products" which are not included on the Drug List, unless specifically covered elsewhere in this Policy and/or such coverage is required in accordance with applicable law or regulatory guidance.

20. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

21. Drugs, that the use or intended use of which would be illegal, abusive, not Medically Necessary.

22. Drugs to treat sexual dysfunction.

23. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction, which is not covered under your Policy, or for which benefits have been exhausted.

24. Drugs which are not included on the *Drug List,* unless specifically covered elsewhere in this Policy and/or such coverage is required in accordance with applicable law or regulatory guidance.

25. Drugs which are repackaged by a company other than the original manufacturer.

26. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and vaccinations administered through certain Participating Pharmacies); and drugs or covered devices for which no valid Prescription Order is obtained.

27. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Policy. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

28. Institutional packs and drugs which are repackaged by anyone other than the original manufacturer.

29. Medications in depot or long-acting formulations that are intended for use longer than the covered days' supply amount.

30. New-to-market FDA-Approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

31. Non-FDA approved drugs.

32. Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary), including but not limited to preservatives, solvents, ointment bases, and flavoring coloring diluting emulsifying and suspending agents.

33. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined.

34. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

35. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit benefits to only one of the therapeutic equivalents available, as specified on the Drug List. If you do not choose the therapeutic equivalents that are covered under the Outpatient Prescription Drug Program benefit section, the drug purchased will not be covered under any benefit level.

36. Vitamins (except prenatal vitamins when prescribed by a Physician or Advanced Practice Nurse, and those vitamins which by law require a Prescription Order and for which there is no non– prescription alternative).

PROGRAM PAYMENT PROVISIONS

LIFETIME MAXIMUM

The total dollar amount that will be available in benefits for you, under this Policy, is unlimited.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket expense limits applicable to Covered Services received from Participating and Non-Participating Providers.

For Participating Provider

If, during one Benefit Period, your Out-of-Pocket expense (the amount remaining unpaid after benefits have been provided) equals the individual Out-of-Pocket expense limit on the Schedule Page of this Policy, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that Benefit Period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This Out-of-Pocket expense limit may be reached by:

1. The Participating Provider calendar year Deductible.
2. Charges for Outpatient prescription drugs.
3. The Hospital emergency room per occurrence Copayment.
4. The urgent care facility Copayment.
5. The Participating Provider Inpatient Copayment.
6. The Participating Provider Outpatient Surgical Copayment.
7. The Deductible amount for Diagnostic Services.
8. The payments for which you are responsible after benefits have been provided (except for the cost difference between the Hospital's rate for a private room and a semi-private room or any expenses incurred for Covered Services rendered by a Non-Participating or Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious).

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

1. Charges that exceed the Eligible Charge or Maximum Allowance.
2. The Coinsurance resulting from Covered Services rendered by a Non-Participating Provider.
3. Copayments resulting from noncompliance with the provisions of the Utilization Management and/or the Blue Cross and Blue Shield Behavioral Health Unit.
4. Services, supplies, or charges limited or excluded in this Policy.
5. Expenses not covered because a benefit maximum, if any, has been reached.
6. Benefit reductions resulting from receiving Covered Drugs from a Pharmacy, which is not a Participating Pharmacy Provider.
7. Benefit reductions resulting from receiving Prescription Drugs from a Non-Participating Pharmacy.
8. Prohibited Third Party Cost Sharing Payments.

If you have Family Coverage, each member of your family must satisfy the Out-of-Pocket expense limit. If your family's Out-of-Pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals the amount specified on the Schedule Page of this Policy during one Benefit Period, then, for the rest of the Benefit Period, all

other family members will have benefits for eligible Covered Services (except for those charges excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.

For Non-Participating Providers

If, during one Benefit Period, your Out-of-Pocket expense (the amount remaining unpaid after benefits have been provided) equals the individual Out-of-Pocket expense limit on the Schedule Page of this Policy, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that Benefit Period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This Out-of-Pocket expense limit may be reached by:

1. The Non-Participating Provider calendar year Deductible.
2. The Hospital emergency room per occurrence Copayment.
3. The Non-Participating Provider Inpatient Deductible.
4. The Non-Participating Provider Outpatient Surgical Copayment.
5. The Deductible amount for Diagnostic Services.
6. The payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided (except for the cost difference between the Hospital's rate for a private room and a semi-private room).

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

1. Charges that exceed the Eligible Charge or Maximum Allowance.
2. The Coinsurance resulting from Covered Services you may receive from a Participating Provider.
3. Copayments resulting from noncompliance with the provisions of the Utilization Management and/or the Blue Cross and Blue Shield Behavioral Health Unit.
4. Services, supplies, or charges limited or excluded in this Policy.
5. Expenses not covered because a benefit maximum, if any, has been reached.

If you have Family Coverage, each member of your family must satisfy the Out-of-Pocket expense limit. If your family's Out-of-Pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals the amount specified on the Schedule Page of this Policy during one Benefit Period then, for the rest of the Benefit Period all other family members will have additional eligible Claims for Non-Participating Providers (except for those charges excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. When there is no Out-of-Pocket expense limit for Non-Participating Providers, as set forth in the Schedule Page of this Policy, you will continue to be responsible for any Deductible, Coinsurance Amount and/or Copayment Amount for Covered Services received from Non-Participating Providers.

These Out-of-Pocket **expense limit amounts are subject to change or increase as permitted by applicable law or regulatory guidance.**

EXCLUSIONS—WHAT IS NOT COVERED

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

1. Hospitalization, services and supplies which are not Medically Necessary.

No benefits will be provided for services which are not 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, 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.

In making decisions of whether the hospitalization or other health care service(s) or supply(ies) are not Medically Necessary, and therefore not eligible for payment under the terms of your Policy, Blue Cross and Blue Shield will apply generally accepted medical standards and will take into account the information submitted to Blue Cross and Blue Shield by the covered person's Provider(s), including any consultations with such Provider(s).

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

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

1. Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
2. Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
3. Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require a continued stay in a Hospital.
4. 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.
5. 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.
6. 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.

Certain services are covered pursuant to Blue Cross and Blue Shield medical policies and clinical procedure and coding policies, which are updated throughout the plan year. The medical policies are guides considered by Blue Cross and Blue Shield when making coverage determinations and lay out the procedure and criteria to determine whether a service, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is an exclusion under this Policy as set forth in this section, *Exclusions—What Is Not Covered*. The clinical procedure and coding policies provide information about what services are reimbursable under the benefit plan. The most up-to-date medical and clinical procedure and coding policies are available at *www.bcbsil.com*, or by calling the phone number on the back of your identification card.

In most instances the decision whether hospitalization or other health care services or supplies were Medically Necessary will be made **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 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's decision, your Policy provides for an appeal of that decision. You must exercise your right to appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so within 180 days after you have been notified that your Claim has been denied by writing to:

Blue Cross and Blue Shield of Illinois
P.O. Box 660603
Dallas, TX 75266-0603

You may furnish or submit additional documentation which you or your Physician believe appropriate.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, OR APPROVES HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES, DOES NOT MEAN THAT THEY WILL BE MEDICALLY NECESSARY AS DEFINED IN THIS POLICY AND IS NOT A GUARANTEE OF BENEFITS SERVICES OR SUPPLIES THAT ARE NOT SPECIFICALLY MENTIONED IN THIS POLICY.

1. Services or supplies provided outside of Illinois, with the following exceptions: (1) emergency or urgent care, (2) services or supplies received after the Member is granted an approved service area waiver, (3) services or supplies received from Participating Providers that do not require a service area waiver. For more information about how to request a service area waiver, contact Customer Service. To identify Participating Providers outside of Illinois that do not require a service area waiver, consult the current online provider directory.
2. 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.
3. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received (except in the case of Medicare), except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 §1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
4. 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.
5. Services or supplies that do not meet accepted standards of medical and/or dental practice.
6. Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under this Policy for:
   a. Routine Patient Costs associated with Experimental/Investigational cancer treatment, if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this Policy if not provided in connection with a qualified cancer trial program, and
   b. Applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

You may contact Customer Service at the toll-free telephone number on the back of your Identification Card for more information about what Experimental/Investigational Services or Supplies may be excluded;

7. Custodial Care Service;
8. Clinical technology, services, procedures and service paradigms designated by a temporary (CPT® Category III) code are not covered except for certain services otherwise specified by state or federal law or federal coverage or billing guidelines.
9. Long Term Care Service.
10. Respite Care Service, except as specifically mentioned under the Hospice Care Program section of this Policy.
11. Inpatient Private Duty Nursing.
12. Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. However, this exclusion does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
13. 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.
14. 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.
15. Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
16. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
17. Special braces, specialized equipment, appliances, ambulatory apparatus, except as specifically mentioned in this Policy.
18. Services or supplies for:
    a. intersegmental traction.
    b. all types of home traction devices and equipment.
    c. vertebral axial decompression sessions.
    d. surface EMGs.
    e. spinal manipulation under anesthesia.
    f. muscle testing through computerized kinesiology machines such as Isostation Digital Myograph and Dynatron.
    g. balance testing through computerized dynamic posturography sensory organization test.
    h. Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy.
18. Blood derivatives which are not classified as drugs in the official formularies.
19. Eyeglasses, contact lenses or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye which are not Medically Necessary, except as specifically mentioned in this Policy. This exclusion is not applicable to children as described in this Policy.

20. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care.

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

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

23. Immunizations, unless otherwise specified in this Policy.

24. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Policy.

25. Acupuncture, whether for medical or anesthesia purposes, dry needling, or trigger acupuncture.

26. Maintenance Care.

27. Diagnostic Service as part of 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 Experimental/Investigational, unless otherwise specified in this Policy.

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

29. Wigs: This plan provides benefits for one wig per benefit period (also referred to as a cranial prostheses) for hair loss caused by:

    1. Chemotherapy
    2. Radiation therapy; or
    3. Alopecia

30. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically mentioned in this Policy.

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

32. Testing of:

    - blood for measurement of levels of: Lipoprotein a; small dense low-density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels;
    - urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover.
    - cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes).
    - Thyroid Disease Testing is not covered in the following situations:
        - Testing for thyrotropin-releasing hormone (TRH) or thyroxine-binding globulin (TBG) for the evaluation of the cause of hyperthyroidism or hypothyroidism is not covered.
        - Testing for thyroid dysfunction during a general exam without abnormal findings for asymptomatic nonpregnant individuals is not covered.
    - Onychomycosis Testing is not covered in the following situations:
        - Nucleic acid testing, attenuated total-reflectance fourier transform infrared (ATR-FTIR) spectroscopy and testing for the presence of fungal-derived sterols (e.g., ergosterol) to screen for, diagnose, or confirm onychomycosis is not covered.

33. Reversals of vasectomies.

34. Charges for medication, drugs, or hormones to stimulate growth.

35. Any drugs and medicines, except as may be provided under Outpatient Prescription Drugs that are:

    a. Dispensed by a Pharmacy and received by you while covered under this Policy,

    b. Dispensed in a Provider's office or during confinement in a Hospital or other acute care institution or facility and received by you for use on an Outpatient basis,

    c. Over-the-counter drugs and medicines; or drugs for which no charge is made,

    d. Prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations; or

    e. Retin-A or pharmacological similar topical drugs.

36. Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Policy.

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

38. Notwithstanding any provision in this Policy to the contrary, any services and/or supplies provided to you outside the United States, unless you receive Emergency Accident Care or Emergency Medical Care.

39. Any related services to a non-covered service except for routine patient care for participants in an Approved Clinical Trial. Related services are:

    a. Services in preparation for the non-covered service.

    b. Services in connection with providing the non-covered service.

    c. Hospitalization required to perform the non-covered service; or

    d. Services that are usually provided following the non-covered service, such as follow-up care or therapy after Surgery.

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

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

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

42. Cannabis – This plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing a delta-9-tetrahydrocannabinol (THC) concentration of more than three-tenths percent (0.3%) on a dry weight basis, whether growing or not, the seeds of the plan, the resin extracted from any part of the plan, and every compound, manufacture, salt, derivative, mixture or preparation of the plan, its seeds or its resin. Cannabis plants with concentrations of THC above 0.3% may be called marijuana plants.

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

1. Services with a primary diagnosis that is not Autism Spectrum Disorder.

2. Services that are facilitated by a Provider that is not properly credentialed; Please see the definition of "Qualified ABA Provider" in the *Definitions Section* of this Policy.

3. Activities primarily of an educational nature.

4. Shadow or companion services; or

5. Any other services not provided by an appropriately licensed Behavioral Health Practitioner in accordance with nationally accepted treatment standards.

HOW TO FILE A CLAIM

In order to obtain your benefits under this Policy, it is necessary for a Claim to be filed with Blue Cross and Blue Shield. To file a Claim, usually all you will have to do is show your Blue Cross and Blue Shield identification card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember, however, it is your responsibility to ensure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

Once Blue Cross and Blue Shield receives your Claim, it will be processed. The benefit payment for eligible Claims will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases, Blue Cross and Blue Shield will send the payment directly to you (for example, when you have already paid your Physician) or executed a valid Assignment of Benefits, as described below.

In certain situations, you will have to file your own Claims. There may be situations when you have to file your own Claim. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from Blue Cross and Blue Shield at *www.bcbsil.com*. In addition, upon receipt of a notice of a claim, Blue Cross and Blue Shield will furnish to you the Claim Form(s) within 15 days. If Blue Cross and Blue Shield does not provide the Claim Form within such 15 days, you will be deemed to have complied with the Claim filing requirements of this Policy for such Claim upon submitting, within the time period required by this Policy, written proof of such Claim along with the details required by subsection 2. below.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis (including appropriate codes), the date of service and a description of the service (including appropriate codes) and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P.O. Box 660603
Dallas, TX 75266-0603

In any case, Claims must be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished in the succeeding calendar year.) For purposes of this filing time limit, Covered Services rendered in the last month of a particular calendar year will be considered to have been rendered in the next calendar year. **Claims not filed within the required time period will not be eligible for payment**.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits for Outpatient prescription drugs. This is primarily true when you did not receive an identification card, the Pharmacy was unable to transmit a Claim, or you received benefits from a non–Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a prescription drug Claim Form. These forms are available from your local Blue Cross and Blue Shield office or *www.bcbsil.com*.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Prime Therapeutics
P.O. Box 25136
Lehigh Valley, PA 18002-5136

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received will not be eligible for payment.

Should you have any questions about filing Claims, please call Blue Cross and Blue Shield.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS INITIAL CLAIMS DETERMINATIONS

Blue Cross and Blue Shield will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. Blue Cross and Blue Shield will usually notify you, your valid assignee or your authorized representative, when all information required to process a Claim in accordance with the terms of the benefit program within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provision in the *General Provisions* section of your Policy.)

If a Claim Is Denied or Not Paid in Full

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

1. The reasons for determination.
2. A reference to the benefit plan provisions, on which the denial is based, or the contractual, administrative or protocol for the determination.
3. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary.
4. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.
5. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review). Specifically, this explanation will include:
    a. An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);
    b. An explanation that you may ask for an external review with an Independent Review Organization (IRO) not associated with Blue Cross and Blue Shield if your appeal was denied based on any of the reasons below. You may also ask for external review if Blue Cross and Blue Shield failed to give you a timely decision (see d. below), and your Claim was denied for one of these reasons:
        i. A decision about the medical need for or the Experimental status of a recommended treatment.
        ii. Your health care coverage was rescinded. For additional information, see the definition of Rescission in the *Definitions Section* of this Policy.
    c. To ask for an external review, complete the Request for External Review form that will be provided to you and available at *insurance.illinois.gov/external review* and submit it to the Department of Insurance at the address shown below for external reviews; An explanation that you may ask for an expedited (urgent) external review if:
        i. Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health or ability to regain maximum function.
        ii. Blue Cross and Blue Shield failed to give you a decision within 48 hours of your request for an expedited appeal; or
        iii. The request for treatment is Experimental or Investigational and your health care Provider states in writing that the treatment would be much less effective if not promptly started.

d. If the written notice is for a Final Adverse Determination, the notice will include an explanation that you may ask for an expedited (urgent) external review if the Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received Emergency Services, but has not been discharged from a facility.

e. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield sends you a written decision for appeals that need medical review within 15 business days after we receive any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. Decisions on expedited appeals are considered timely if Blue Cross and Blue Shield sends you a written decision with 48 hours of your request for an expedited appeal.

6. In certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);

7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield.

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

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

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

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

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

For complaints and general inquiries:

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

Chicago Office
115 South LaSalle Street, 13th Floor
Chicago, IL 60603
(312) 814-2420: phone
(312) 814-5146: fax
DOI.complaints@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit

320 West Washington Street 4th Floor
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Timing of Required Notices and Extensions

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

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

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

3. **Post-Service Claim** is notification in a form acceptable to Blue Cross and Blue Shield 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 may request in connection with services rendered to you.

Urgent Care Clinical Claims*

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

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

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

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, Blue Cross and Blue Shield must notify you within:	5 days*
If your Claim is incomplete, Blue Cross and Blue Shield must notify you within:	15 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to Blue Cross and Blue Shield within:	45 days after receiving notice
Blue Cross and Blue Shield must notify you of the Claim *determination (whether adverse or not):*	

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

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

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

Post-Service Claims

Type of Notice or Extension	Timing
If your Claim is incomplete, Blue Cross and Blue Shield must notify you within:	30 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to Blue Cross and Blue Shield within:	45 days after receiving notice
Blue Cross and Blue Shield must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete, within:	30 days*
after receiving the completed Claim (if the initial Claim is incomplete), within:	45 days

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

Concurrent Care

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

INQUIRIES AND COMPLAINTS

An “Inquiry” is a general request for information regarding Claims, benefits, or membership. A “Complaint” is an expression of dissatisfaction by you either orally or in writing.

Blue Cross and Blue Shield has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

1. Claims.
2. Quality of care.

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

To pursue an Inquiry or a Complaint, you may call customer service at the number on the back your identification card or you may write to:

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

When you contact customer service to pursue an Inquiry or Complaint, you will receive a written response to your Inquiry or Complaint within 30 days of receipt. Sometimes the acknowledgement and the response will be combined. If Blue Cross and Blue Shield needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by Blue Cross and Blue Shield, its employees or a Participating Provider.

CLAIM APPEAL PROCEDURES

Claim Appeal Procedures — Definitions

An "Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. If an Ongoing Course of Treatment had been approved by Blue Cross and Blue Shield, and Blue Cross and Blue Shield reduces or terminates such treatment (other than by amendment or termination of this Policy) before the end of the approved treatment period, which is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. Please refer to the provision entitled "Rescission" in the *Coverage and Premium Information* section of this Policy for additional information.

In addition, an Adverse Benefit Determination also includes an "Adverse Determination." An "Adverse Determination" means:

1. A determination by Blue Cross and Blue Shield or its designee utilization review organization that, based upon the information provided, a request for a benefit under Blue Cross and Blue Shield's health benefit plan upon application of any utilization review technique does not meet Blue Cross and Blue Shield's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be Experimental or Investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; or
2. A Rescission of coverage. Please refer to the provision entitled "Rescission" in the *Coverage and Premium Information* section of this Policy for additional information.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis.

An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, as well as continued hospitalization. Before authorization of benefits for an Ongoing Course of Treatment is terminated or reduced, Blue Cross and Blue Shield will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the Ongoing Course of Treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Blue Cross and Blue Shield will render a decision on the appeal within 24 hours after it receives the requested information, but in no event more than 48 hours after the appeal has been received by Blue Cross and Blue Shield.

How to Appeal an Adverse Benefit Determination

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

An appeal of an Adverse Benefit Determination may be filed by you, or a person authorized to act on your behalf. In some circumstances, a health care Provider may appeal on his/her own behalf. Under your Health Benefit Plan, there is one level of internal appeal available to you. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call Blue Cross and Blue Shield at the number on the back of your identification card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

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

1. Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to Blue Cross and Blue Shield to request a Claim review. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the Adverse Benefit Determination.

2. In support of your Claim review, you have the option of presenting evidence and testimony to Blue Cross and Blue Shield. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.

3. To contact Blue Cross and Blue Shield to request a Claim review or appeal an Adverse Benefit Determination, use the following contact information:

Blue Cross and Blue Shield of Illinois
P.O. Box 660603
Dallas, TX 75266-0603
(800) 538-8833 Toll-free number
(866) 414-4258 Fax number
(918) 551-2011 Fax number for Urgent requests
send a secure email by using our message center by logging into Blue Access for Members℠ (BAM) at
www.bcbsil.com

During the course of your internal appeal(s), Blue Cross and Blue Shield will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by Blue Cross and Blue Shield in connection with the appealed Claim, as well as any new or additional rationale for a denial at the internal appeals stage.

Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. Blue Cross and Blue Shield may extend the time period described in this Policy for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgment, the appeal will be conducted by individuals associated with Blue Cross and Blue Shield and/or by external advisors, but who were not involved in making the initial denial of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by Blue Cross and Blue Shield (except in situations where you are not required to exhaust the appeals process).

Upon receipt of a non-urgent concurrent, pre-service or post-service appeal, Blue Cross and Blue Shield will notify the party filing the appeal within three business days of all the information needed to review the appeal.

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

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

Notice of Appeal Determination

Blue Cross and Blue Shield will notify the party filing the appeal, you, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal.

The written notice will include:

1. The reasons for the determination.
2. A reference to the benefit plan provisions, on which the determination is based, or the contractual, administrative or protocol for the determination.
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.
4. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal. Specifically, this explanation will include:
    a. An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add).
    b. An explanation that you may ask for an external review with an Independent Review Organization (IRO) not associated with Blue Cross and Blue Shield if your appeal was denied based on any of the reasons below. You may also ask for external review if Blue Cross and Blue Shield failed to give you a timely decision (see d. below), and your Claim was denied for one of these reasons:
        i. A decision about the medical need for or the Experimental status of a recommended treatment.
        ii. Your health care coverage was rescinded. For additional information, see the definition of Rescission in the *Definitions Section* of this Policy.

        To ask for an external review, complete the Request for External Review form that will be provided to you and available at *insurance.illinois.gov/external review* and submit it to the Department of Insurance at the address shown below for external reviews.
    c. An explanation that you may ask for an expedited (urgent) external review if:
        i. Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health or ability to regain maximum function.
        ii. Blue Cross and Blue Shield failed to give you a decision within 48 hours of your request for an expedited appeal; or
        iii. The request for treatment is Experimental or Investigational and your health care Provider states in writing that the treatment would be much less effective if not promptly started; or
        iv. The Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received Emergency Services, but has not been discharged from a facility.
    d. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield sends you a written decision for appeals that need medical review within 15 business days after we receive any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've

already received the service. Decisions on expedited appeals are considered timely if Blue Cross and Blue Shield sends you a written decision within 48 hours of your request for an expedited appeal.

5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative.

6. In certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);

7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield.

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

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

10. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request.

11. A description of the standard that was used in denying the Claim and a discussion of the decision.

12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review.

13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review.

14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a Provider appeal.

15. The number of levels of appeals available (one level for individual) under the plan and the level of appeal applicable to the adverse determination within the notice;

16. A Request for External Review Form, Authorized Representative Form, (HCP) Health Care Provider Certification – Request for Expedited Review Form, and (HCP) Health Care Provider Certification – Experimental/Investigational Review Form; and

17. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For complaints and general inquiries:

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

Chicago Office
115 South LaSalle Street, 13th Floor

Chicago, IL 60603
(312) 814-2420: phone
(312) 814-5146: fax
DOI.complaints@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington Street 4th Floor
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
*Doi.externalreview@illinois.gov*Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

If Blue Cross and Blue Shield's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your Claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the "Independent External Review" provision below.

You may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify Blue Cross and Blue Shield of the Complaint. Blue Cross and Blue Shield will have 21 days to respond to the Illinois Department of Insurance.

The operations of Blue Cross and Blue Shield are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

Illinois Department of Insurance can be contacted at:

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

Chicago Office
115 South LaSalle Street, 13th Floor
Chicago, IL 60603
(312) 814-2420: phone
(312) 814-5146: fax
DOI.complaints@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

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

If You Need Assistance

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

Blue Cross and Blue Shield of Illinois
P.O. Box 660603
Dallas, TX 75266-0603
(800)-538-8833 Toll-free phone

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

INDEPENDENT EXTERNAL REVIEW

You or your authorized representative may make a request for a standard external or expedited external review of an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

A "Final Adverse Determination" means an Adverse Determination involving a Covered Service that has been upheld by Blue Cross and Blue Shield or its designated utilization review organization, at the completion of Blue Cross and Blue Shield's internal grievance process procedures.

1. **Standard External Review.** You or your authorized representative must submit a written request for a standard external independent review to the Illinois Department of Insurance ("IDOI") within four months of receiving an Adverse Determination or Final Adverse Determination. Your request should be submitted to the IDOI at the following address:

   Illinois Department of Insurance
   Office of Consumer Health Insurance
   External Review Unit
   320 W. Washington Street 4th Floor
   Springfield, IL 62767
   (877) 850-4740 Toll-free phone
   (217) 557-8495 Fax number
   Doi.externalreview@illinois.gov Email address
   https://mc.insurance.illinois.gov/messagecenter.nsf

You may submit additional information or documentation to support your request for the health care services. Within one business day after the date of receipt of the request, the IDOI will send a copy of the request to Blue Cross and Blue Shield.

2. **Preliminary Review**. Within five business days of receipt of the request from the IDOI, Blue Cross and Blue Shield will complete a preliminary review of your request to determine whether:

   a. You were a covered person at the time health care service was requested or provided;

   b. The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this Policy, but Blue Cross and Blue Shield has determined that the health care service is not covered.

   c. You have exhausted Blue Cross and Blue Shield's internal appeal process, unless you are not required to exhaust Blue Cross and Blue Shield's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and

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

For appeals relating to a determination based on treatment being Experimental or Investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Blue Cross and Blue Shield's determination that the service or treatment is Experimental or Investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, your health care Provider has certified that one of the following situations is applicable:

a. Standard health care services or treatments have not been effective in improving your condition.

b. Standard health care services or treatments are not medically appropriate for you.

c. There is no available standard health care services or treatment covered by Blue Cross and Blue Shield that is more beneficial than the recommended or requested service or treatment; or

In addition, a) your health care Provider has certified in writing that the health care service or treatment is likely to be more beneficial to you, in the opinion of your health care Provider, than any available standard health care services or treatments, or b) your health care Provider who is licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.

3. **Notification**. Within one business day after completion of the preliminary review, Blue Cross and Blue Shield shall notify the IDOI, you and your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the IDOI, you and your authorized representative shall be notified by Blue Cross and Blue Shield in writing of what materials are required to make the request complete or the reason for its ineligibility. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, The IDOI's decision shall be in accordance with the terms of your benefit program (unless such terms are inconsistent with applicable laws) and shall be subject to all applicable laws.

4. **Assignment of IRO**. When the IDOI receives notice that your request is eligible for external review following the preliminary review, the IDOI will, within one business day after the receipt of the notice, a) assign an IRO on a random basis from those IROs approved by the IDOI; and (b) notify Blue Cross and Blue Shield, you and your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Within five business days after the date of receipt of the notice provided by the IDOI of assignment of an IRO, Blue Cross and Blue Shield provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may, within five business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after five business days. If Blue Cross and Blue Shield or its designated utilization review organization does not provide the documents and information within five business days, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by Blue Cross and Blue Shield or designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the external review. Within one business day after making the decision to end the external review, the IRO shall notify Blue Cross and Blue Shield, you and, if applicable, your authorized representative, of its decision to reverse the determination.

If you or your authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to Blue Cross and Blue Shield within one business day of receipt from you or your authorized representative. Upon receipt of such information, Blue Cross and Blue Shield may reconsider the Adverse Determination or Final Adverse Determination. Such reconsideration shall not delay the external review. Blue Cross

and Blue Shield may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the external review, Blue Cross and Blue Shield shall notify the IDOI, the IRO, you, and if applicable, your authorized representative of its decision to reverse the determination.

5. **IRO's Decision.** In addition to the documents and information provided by Blue Cross and Blue Shield and you, or if applicable, your authorized representative, the IRO shall also consider the following information if available and appropriate:

   a. Your pertinent medical records.

   b. Your health care Provider's recommendation.

   c. Consulting reports from appropriate health care Providers and other documents submitted to Blue Cross and Blue Shield or its designee utilization review organization, you, your authorized representative or your treating Provider.

   d. The terms of coverage under the benefit program.

   e. The most appropriate practice guidelines, which shall 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.

   f. Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield or its designated utilization review organization; and

   g. The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

Within one business day after the receipt of notice of assignment to conduct an external review with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is Experimental or Investigational, the IRO will select one or more clinical reviewers, as it determines is appropriate, to conduct the external review, which clinical reviewers must meet the minimum qualifications set forth in the Illinois Health Carrier External Review Act, and neither you, your authorized representative, if applicable, nor Blue Cross and Blue Shield will choose or control the choice of the Physicians or other health care professional to be selected to conduct the external review. Each clinical reviewer will provide a written opinion to the IRO within 20 days after being selected by the IRO to conduct the external review on whether the recommended or requested health care service or treatment should be covered.

The IRO will make a decision within 20 days after the date it receives the opinion of each clinical reviewer, which will be determined by the recommendation of a majority of the clinical reviewers.

Within five days after the date of receipt of the necessary information, but in no event more than 45 days after the date of receipt of request for an external review, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the IDOI, Blue Cross and Blue Shield, you and your authorized representative, if applicable, of its decision.

With respect to Experimental or Investigational services or treatment, the IRO will make a decision within 20 days after the date it receives the opinion of each clinical reviewer, which will be determined by the recommendation of a majority of the clinical reviewers.

The written notice will include:

a. A general description of the reason for the request for external review.

b. The date the IRO received the assignment from the IDOI.

c. The time period during which the external review was conducted.

d. References to the evidence or documentation including the evidence-based standards, considered in reaching its decision or in the case of external reviews of Experimental or Investigational services or treatments, the written opinion of each clinical reviewers as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation.

e. The date of its decisions.

f. The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and

g. The rationale for its decision.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review.

The IRO is not bound by any claim determination reached prior to the submission of information to the IRO. The IDOI, you, and your authorized representative, if applicable, and Blue Cross and Blue Shield will receive written notice from the IRO. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance.

6. **Expedited External Review**

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination; (b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received Emergency Services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of a Final Adverse Determination or if Blue Cross and Blue Shield fails to provide a decision on a request for an expedited internal appeal within 48 hours.

You may also request an expedited external review if a Final Adverse Determination concerns a denial of coverage based on the determination that the treatment or service in question is considered Experimental or Investigational and your health care Provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

Expedited external review will not be provided for retrospective adverse or final adverse determinations. Your request for an expedited independent external review may be submitted to the IDOI either orally (by calling the phone number) or in writing as set forth above for requests for standard external review.

7. **Notification**. Upon receipt of a request for an expedited external review, the IDOI shall immediately send a copy of the request to Blue Cross and Blue Shield. Blue Cross and Blue Shield shall immediately notify the IDOI, you and your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, IDOI's decision shall be in accordance with the terms of the benefit program (unless such terms are inconsistent with applicable law) and shall be subject to all applicable laws.

8. **Assignment of IRO**. If your request is eligible for expedited external review, the IDOI shall immediately assign an IRO on a random basis from the list of IROs approved by the IDOI; and immediately notify Blue Cross and Blue Shield of the name of the IRO.

Upon receipt from the IDOI of the name of the IRO assigned to conduct the external review, Blue Cross and Blue Shield or its designated utilization review organization shall, immediately (but in no case more than 24 hours after receiving such notice) provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may submit additional information in writing to the assigned IRO within 24 hours or additional information may accompany the request for an expedited independent external review. If Blue Cross and Blue Shield or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the external review, the IRO shall notify the IDOI, Blue Cross and Blue Shield, you and, if applicable, your authorized representative, of its decision to reverse the determination.

As expeditiously as your medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited external review), the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the IDOI, Blue Cross and Blue Shield, you and, if applicable, your authorized representative. If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the IDOI, Blue Cross and Blue Shield and, if applicable, your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of Experimental or Investigational Treatments, each clinical reviewer shall provide an opinion orally or in writing to the assigned IRO as expeditiously as our medical condition or circumstances requires, but in no event more than five calendar days after being selected. Within 48 hours after the date, it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing to the IDOI, Blue Cross and Blue Shield, you and your authorized representative, if applicable.

If the IRO's initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the IDOI, Blue Cross and Blue Shield, and if applicable, your authorized representative.

The assigned IRO is not bound by any decisions or conclusions reached during Blue Cross and Blue Shield's utilization review process or Blue Cross and Blue Shield's internal grievance appeal. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance's Office of Consumer Health Insurance.

An external review decision is binding on Blue Cross and Blue Shield. An external review decision is binding on you, except to the extent you have other remedies available under applicable federal or state law. You and your authorized representative may not file a subsequent request for external review involving the same Adverse Determination or Final Adverse Determination for which you have already received an external review decision.

COORDINATION OF BENEFITS SECTION

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

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

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

In addition to the Definitions Section of this Policy, the following definitions apply to this section:

ALLOWABLE EXPENSE – means a Covered Service, when the Covered Service is covered at least in party by one or more benefit program covering the person for whom the Claim is made.

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

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

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

1. Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

Each contract or other arrangement under 1. or 2. above is a separate Benefit Program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate program.

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION

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

1. The other Benefit Program has rules coordinating its benefits with those of this Benefit Program; and

2. Both those rules and this Benefit Program's rules, rule 3 below require that this Benefit Program's benefits be determined before those of the other Benefit Program.

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

1. Non-Dependent or Dependent

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

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

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

2. Dependent Child if Parents not Separated or Divorced

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

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

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

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

3. Dependent Child if Parents Separated or Divorced

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

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

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

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

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

4. Dependent Child if Parents Share Joint Custody

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

5. Young Adult as a Dependent

   For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, rule 8, "Length of Coverage" applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both

parents' plans, the order of benefits shall be determined by applying the birthday rule of rule 2 to the dependent child's parent or parents and the dependent's spouse.

6. Active or Inactive Employee

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

7. Continuation Coverage

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

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

   b. Second, the benefits under the continuation coverage.

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

8. Length of Coverage

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

The benefits of this Benefit Program will be reduced when:

1. The benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. Blue Cross and Blue Shield has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give Blue Cross and Blue Shield any facts it needs to pay the Claim.

FACILITY OF PAYMENT

A payment made under other valid coverage may include an amount that should have been paid under this Policy. If it does, Blue Cross and Blue Shield may pay that amount to the organization that made the payment under the other Benefit Program. That amount will then be treated as though it were a benefit paid under this Policy. Blue Cross and Blue Shield

will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by Blue Cross and Blue Shield is more than it should have paid under this COB provision, it may recover the excess from one or more of:

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

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

GENERAL PROVISIONS

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

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers ("Participating 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 is a party, including all persons covered under this Policy. Under certain circumstances described in its contracts with Participating Providers, Blue Cross and Blue Shield may:

a. Receive substantial payments from Participating Providers with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Participating Provider, or

b. Pay Participating Providers substantially less than their Claim Charges for services, by discount or otherwise, or

c. Receive from Participating Providers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Hospitals and other facilities, the calculation of any Out-of-Pocket maximums or any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Policy and the calculation of all required Deductible and Coinsurance amounts payable by you under this Policy 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. Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. You are not entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the Deductible and Coinsurance amounts set out in your Policy.

c. However, for purposes of calculating your Deductible and Coinsurance amounts, and whether you have reached any Out-of-Pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your Deductible and Coinsurance amounts, and whether you have reached any Out-of-Pocket or benefit maximums.

d. Assuming you have already satisfied your Deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the Deductible and Coinsurance amounts, Blue Cross and Blue Shield will satisfy its portion of the Hospital bill. In most cases, Blue Cross and Blue Shield has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money Blue Cross and Blue Shield would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your Deductible has already been satisfied, and your Coinsurance is $140, then Blue Cross and Blue Shield has to satisfy the rest of the Hospital bill, or $860. Assuming Blue Cross and Blue Shield has a contract with the Hospital, Blue Cross and Blue Shield will usually be able to satisfy the $860 bill that remains after your Coinsurance and Deductible, by paying less than $860 to the Hospital, often substantially less than $860. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the $860 bill and whatever Blue Cross and Blue Shield ultimately pays under its contracts with Participating Providers, and you are not entitled to any part of these savings.

2. Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers Out-of-Area Services

Blue Cross and Blue Shield of Illinois has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you access healthcare services outside of the Blue Cross and Blue Shield of Illinois service area, the Claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program.

When you receive care outside of the Blue Cross and Blue Shield of Illinois service area, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain how we pay both types of Providers below.

3. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Illinois will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

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

Whenever you receive Covered Services outside the Blue Cross and Blue Shield of Illinois service area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

a. The billed covered charges for your Covered Services, or

b. The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Illinois. To help you understand how this calculation would work, please consider the following example:

   i. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your identification card to the Provider to let him or her know that you are covered by Blue Cross and Blue Shield of Illinois.

   ii. The Provider has negotiated with the Host Blue a price of $80, even though the Provider's standard charge for this service is $100. In this example, the Provider bills the Host Blue $100.

   iii. The Host Blue, in turn, forwards the Claim to Blue Cross and Blue Shield of Illinois and indicates that the negotiated price for the Covered Service is $80. Blue Cross and Blue Shield of Illinois would then base the amount you must pay for the service -- the amount applied to your Deductible, if any, and your Coinsurance percentage -- on the $80 negotiated price, not the $100 billed charge.

   iv. So, for example, if your Coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a Covered Service.

PLEASE NOTE: The Coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your Deductible and that there are no Copayments associated with the service rendered. Your Deductible(s), Coinsurance and Copayment(s) are specified in this Policy.

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

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

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the Claim Charge passed on to you.

Non-Participating Providers Outside Blue Cross and Blue Shield of Illinois Service Area

1. **Liability Calculation**

   When Covered Services are provided outside of Blue Cross and Blue Shield of Illinois service area by Non-Participating Providers, the amount you pay for such services will generally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Blue Cross and Blue Shield of Illinois will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

2. **Exceptions**

   In certain situations, Blue Cross and Blue Shield of Illinois may use other payment bases to determine the amount Blue Cross and Blue Shield of Illinois will pay for services rendered by Non-Participating healthcare Providers. If a negotiated payment is not available, then Blue Cross and Blue Shield of Illinois may make a payment based on the lesser of: the amount calculated using the methodology described in the Policy for Non-Participating Providers located inside our service area (and described in Section C(a)(1) above): or the following such as: (i) billed covered charges; (ii) the payment we would make if the healthcare services had been obtained within our service area; or (iii) a special negotiated payment, to determine the amount Blue Cross and Blue Shield of Illinois will pay for services rendered by Non-Participating Providers; or (iv) for professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable; or (v) for Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs; that hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility. In these situations, you may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Blue Cross and Blue Shield of Illinois will make for the Covered Services as set forth in this paragraph.

Blue Cross Blue Shield Global Core

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

1. **Emergency Care Services**

   This Policy covers only limited health care services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include Emergency Services, Emergency Accident Care, Emergency Medical Care, and Urgent Care obtained outside of the United States. Follow-up care following an emergency is also available, provided the services have obtained Prior Authorization by Blue Cross and Blue Shield of Illinois. Any other services will not be eligible for benefits unless authorized by Blue Cross and Blue Shield of Illinois.

   If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-.673-1177. 24 hours a day,

seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

2. **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for the covered Inpatient Services, except for your cost-share amount/Deductibles, coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. **You must contact the Plan to obtain Prior Authorization for non-emergency Inpatient Services.**

3. **Outpatient Services**

Outpatient services are only available for Emergency Care. Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

4. **Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the BlueCard service area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International Claim form and send the Claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from Blue Cross and Blue Shield of Illinois, the service center or online at *www.bcbsglobalcore.com*. If you need assistance with your Claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177 24 hours a day, seven days a week.

5. **Blue Cross and Blue Shields' Separate Financial Arrangements with Prescription Drug Providers**

Blue Cross and Blue Shield hereby informs you that it has arrangements with Participating Prescription Drug Providers for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual policies, group health insurance policies and contracts to which Blue Cross and Blue Shield is a party, including this Policy, and that pursuant to Blue Cross and Blue Shield's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, Blue Cross and Blue Shield may receive discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of prescription drugs will vary. Some discounts are currently based on Average Wholesale Price ("AWP") which is determined by a third party and is subject to change.

You understand that Blue Cross and Blue Shield may receive such discounts. You are not entitled to receive any portion of any such discounts. The drug fees/discounts that Blue Cross and Blue Shield has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate your share of the cost of prescription drugs for both retail and mail/specialty drugs. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed through to Blue Cross and Blue Shield (and ultimately to you as described above).

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

a. Assume you have a prescription dispensed and the undiscounted amount of the prescription drug is $100. How is the $100 bill paid?

b. You will have to pay the Coinsurance Amount set out in this Policy.

c. However, for purposes of calculating your Coinsurance Amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 prescription drug bill would be reduced by 20% to $80 for purposes of calculating your Coinsurance Amount.

d. In our example, if your Coinsurance obligation is 25%, you will have to pay 25% of $80, or $20. You should note that your 25% Coinsurance Amount is based upon the discounted amount of the prescription and not the full $100 bill.

For the mail Pharmacy and specialty Pharmacy Match program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail Pharmacy and/or specialty Pharmacy Match program. Blue Cross and Blue Shield pays a fee to Prime for Pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and mail-order processing.

"Weighted paid Claim" refers to the methodology of counting Claims for purposes of determining Blue Cross and Blue Shield's fee payment to Prime. Each retail (including Claims dispensed through PBM's specialty Pharmacy Match program) paid Claim will be weighted according to the days' supply dispensed. A paid Claim is weighted in 34-day supply increments so a 1 - 34 days' supply is considered 1 weighted Claim, a 35 - 68 days' supply is considered 2 weighted Claims and the pattern continues up to 6 weighted Claims for 171 or more days' supply. Blue Cross and Blue Shield pays Prime a Program Management Fee ("PMF") on a per weighted Claim days' supply.

The amounts received by Prime from Blue Cross and Blue Shield, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a Claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Blue Cross and Blue Shield (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Policy. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 5.5% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of Blue Cross and Blue Shield and other Blue Plan operating divisions.

6. **Blue Cross and Blue Shield's Separate Financial Arrangements with Pharmacy Benefit Managers**

Blue Cross and Blue Shield hereby informs you that it owns a significant portion of the equity of Prime and that Blue Cross and Blue Shield has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual policies, group health insurance policies and contracts to which Blue Cross and Blue Shield is a party, including this Policy. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with Blue Cross and Blue Shield. In addition, Prime's mail order Pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of Blue Cross and Blue Shield but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). Blue Cross and Blue Shield may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates in excess of any amount that may be reflected in the premium.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

1. All benefit payments may be made by Blue Cross and Blue Shield of Illinois directly to any Provider furnishing the Covered Services for which such payment is due, and Blue Cross and Blue Shield of Illinois is authorized by you to make such payments directly to such Providers. However, Blue Cross and Blue Shield of Illinois may pay any benefits that are payable under the terms of this Policy directly to you, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by the Plan sufficiently in advance of

Blue Cross and Blue Shield of Illinois' benefit payment. You may be required to submit a copy of the assignment of benefit payments to Blue Cross and Blue Shield of Illinois.

2. Under this Policy, 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. For example, Blue Cross and Blue Shield of Illinois may pay benefits to you if you receive Covered Services from a Non-Participating Provider. Blue Cross and Blue Shield of Illinois is specifically authorized by you to determine to whom any benefit payment should be made.

3. Once Covered Services are rendered by a Provider, you have no right to request Blue Cross and Blue Shield not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, Blue Cross and Blue Shield will have no liability to you or any other person because of its rejection of such request.

4. Except for the assignment of benefit payment described above, neither this Policy, any portion of this Policy, nor your Claim for benefits under this Policy is assignable to any person or entity at any time, and coverage under this Policy is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a Claim for benefits or coverage shall be null and void.

5. The Policyholder retains the right to revoke, on a prospective basis only, such Assignment of Benefit Payments, as long as notice of such revocation is received by Blue Cross and Blue Shield sufficiently in advance of Blue Cross and Blue Shield's benefit payment.

YOUR PROVIDER RELATIONSHIPS

1. The choice of a Provider is solely your choice and Blue Cross and Blue Shield and/or the Exchange will not interfere with your relationship with any Provider.

2. Blue Cross and Blue Shield and/or the Exchange does not undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. Blue Cross and Blue Shield and/or the Exchange is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by Blue Cross and Blue Shield of Illinois and/or the Exchange. Any contractual relationship between a Physician and a Participating Hospital or other Participating Provider shall not be construed to mean that Blue Cross and Blue Shield of Illinois and/or the Exchange is providing professional service.

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

ENTIRE POLICY CHANGES

This Policy, including the Addenda and/or Riders, if any, and the individual application of the Insured constitute the entire contract of coverage. All statements made by an Insured shall, in the absence of fraud, be deemed representations and not warranties, and no such statements shall be used in defense to a Claim under this Policy unless it is contained in a written application. No change in this Policy shall be valid until approved by an executive officer of Blue Cross and Blue Shield and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. The issuance of this Policy supersedes all previous contracts or policies issued to the Insured by Blue Cross and Blue Shield and/or the Exchange.

1. **POLICY YEAR** – means the 12-month period beginning on January 1 of each year.

2. **PREMIUM REBATES, AND PREMIUM ABATEMENTS; AND COST-SHARING**
   a. Rebate. In the event federal or state law requires Blue Cross and Blue Shield to rebate a portion of annual premiums paid, Blue Cross and Blue Shield will provide any rebate as required or allowed by applicable law.

b. Abatement. Blue Cross and Blue Shield may from time to time determine to abate (all or some of) the premium due under this Policy for particular period(s).

c. Any abatement of premium by Blue Cross and Blue Shield represents a determination by Blue Cross and Blue Shield not to collect premium for the applicable period(s) and does not effect a reduction in the rates under this Policy. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future periods.

d. Blue Cross and Blue Shield makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each person owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.

e. Cost-Sharing. Blue Cross and Blue Shield reserves the right from time to time to waive or reduce the Coinsurance, Copayments and/or Deductibles under this Policy.

3. **OTHER COVERAGE WITH BLUE CROSS AND BLUE SHIELD**

Coverage effective at any one time on you under a like policy or policies in this company is limited to the one such policy elected by you, your beneficiary, or your estate, as the case may be, and Blue Cross and Blue Shield will return all premiums paid for all other such policies.

4. **NOTICES**

Any information or notice which you furnish to Blue Cross and Blue Shield under this Policy must be in writing and sent to Blue Cross and Blue Shield at its' offices at 300 East Randolph Street, Chicago, Illinois 60601-5099 (unless another address has been stated in this Policy for a specific situation). Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield's records or, if applicable, in the case of a medical child support court order, to the designated representative as it appears on Blue Cross and Blue Shield's records. Blue Cross and Blue Shield may also provide such notices electronically, to the extent permitted by applicable law.

5. **INFORMATION AND RECORDS**

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Policy, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to other Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same.

6. **LIMITATIONS OF ACTIONS**

No legal action may be brought to recover under this Policy, prior to the expiration of sixty (60) days after a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Policy. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to Blue Cross and Blue Shield in accordance with the requirements of this Policy.

7. **DEATH OF THE INSURED-REFUND OF PREMIUMS**

In the event of the death of the Insured (that is, the person to whom this Policy is issued), Blue Cross and Blue Shield shall provide a refund of any unearned premiums assessed following the death of the Insured; provided,

however, that a written request for a premium refund is received from the representative of the estate of the Insured or the person or entity so entitled.

8. **PHYSICAL EXAMINATION AND AUTOPSY**

Blue Cross and Blue Shield, at its own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

9. **INCONTESTABILITY**

After the Policy has been in force two (2) years from the date of issue, no statement of the Policyholder, except intentional fraudulent misstatements, shall be used to void the Policy; and no statement by any covered person, except intentional fraudulent misstatements, shall be used to reduce or deny a Claim after the insurance coverage, with respect to which a Claim has been made, has been in effect two (2) years or more.

10. **APPLICABLE LAW**

This Policy shall be subject to and interpreted by the laws of the State of Illinois.

11. **SEVERABILITY**

In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Policy, but this Policy shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

12. **SERVICE MARK REGULATION**

You hereby acknowledge your understanding that this Policy constitutes a contract solely between you and Blue Cross and Blue Shield, that Blue Cross and Blue Shield is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the “Association”) permitting us to use the Blue Cross and Blue Shield Service Mark in the state of Illinois, and that we are not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this Policy based upon representations by any person other than Blue Cross and Blue Shield and that no person, entity, or organization other than Blue Cross and Blue Shield shall be held accountable or liable to you for any of our obligations to you created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield other than those obligations created under other provisions of this agreement.

13. **VALUE BASED DESIGN PROGRAMS**

Blue Cross and Blue Shield has the right to offer medical management programs, quality improvement programs, and health behavior wellness, incentive, maintenance, or improvement programs that allows for a reward, a contribution, a differential in premiums or in medical, prescription drug or equipment Copayments, Coinsurance, Deductibles or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by Blue Cross and Blue Shield or an entity chosen by Blue Cross and Blue Shield to administer such program. In addition, discount programs for various health or wellness-related, insurance-related or other items and services may be available from time to time. Such programs may be discontinued with or without notice.

Individuals unable to participate in these incentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, Blue Cross and Blue Shield will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards. Contact Blue Cross and Blue Shield for additional information regarding any value-based programs offered by Blue Cross and Blue Shield.

Blue Cross and Blue Shield makes available, at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity

theft protection services are currently provided by Blue Cross and Blue Shield designated outside vendor and acceptance or declination of these services is optional to Member. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at *www.bcbsil.com* or telephonically by calling the toll-free telephone number on your identification card. Services may automatically end when the person is no longer an eligible member. Services may change or be discontinued at any time with or without notice and Blue Cross and Blue Shield does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this benefit program.

14. **MODIFICATION OF COVERAGE**

Blue Cross and Blue Shield may modify your Policy as required or permitted by applicable law and may modify your Policy at renewal as long as the modification is consistent with applicable state and federal law on a uniform basis.

15. **AGENCY RELATIONSHIPS**

If this Policy is purchased through the Exchange, in no event shall Blue Cross and Blue Shield be considered the agent of the Exchange or be responsible for the Exchange. All information you provide to the Exchange and received by Blue Cross and Blue Shield from the Exchange will be relied upon as accurate and complete. You must promptly notify the Exchange and Blue Cross and Blue Shield of any changes to such information.

16. **OVERPAYMENT**

If Blue Cross and Blue Shield pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or was made in error ("Overpayment"), Blue Cross and Blue Shield has the right to obtain a refund of the Overpayment from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities or organizations, including, but not limited to, Participating Providers or Non-Participating Providers.

If no refund is received, Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment from:

a. Any future benefit payment owed to any person or entity under this Policy, whether for the same or a different Member.

b. Any future benefit payment owed to any person or entity under another Blue Cross and Blue Shield-administered ASO benefit program.

c. Any future benefit payment owed to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy.

d. Any future benefit payment, or other payment, owed to any person or entity; or

e. Any future payment owed to one or more Participating Providers or Non-Participating Providers.

Further, Blue Cross and Blue Shield has the right to reduce your Policy's payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield Plan's or policy's overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield plan or policy.

17. **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS**

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

1. <u>Continuity of Care</u>

If you are under the care of a Participating Provider as defined in this Certificate who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

a. You are undergoing a course of treatment for a serious and complex condition,

b. You are undergoing institutional or Inpatient care,

c. You are scheduled to undergo nonelective Surgery from the Provider (including receipt of postoperative care from such Provider with respect to such Surgery),

d. You are pregnant or undergoing a course of treatment for your pregnancy, or

e. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving Chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized Medical Care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies you of the Provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for benefits under this provision, as explained in the **CLAIM APPEAL PROCEDURES** provision in the **HOW TO FILE A CLAIM** section of this Certificate.

2. Federal No Surprises Act Definitions

The definitions below apply only to this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section. To the extent the same terms are also defined in the **DEFINITIONS SECTION** of this Certificate, those terms will apply only to their use in the Certificate or this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section, respectively.

"**Air Ambulance Services**" means, for purposes of this section only, medical transport by helicopter or airplane for patients.

"**Emergency Medical Condition**" means, for purposes of this section only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"**Emergency Services**" means, for purposes of this section only:

a. A medical screening examination performed in the emergency department of a Hospital or a Freestanding Emergency Department;

b. Further medical examination or treatment you receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until your condition is stabilized; and

c. Covered Services you receive from a Non-Participating Provider during the same visit after your Emergency Medical Condition has stabilized unless:

i. Your Non-Participating Provider determines you can travel by non-medical or non-emergency transport.

ii. Your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and

iii. You have provided informed consent.

"**Non-Participating Provider**" means, for purposes of this section only, with respect to a covered item or service, a Physician or other health care Provider who does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan.

Non-Participating Emergency Facility" means, for purposes of this section only, with respect to a covered item or service, an emergency department of a Hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan.

Participating Provider" means, for purposes of this section only, with respect to a Covered Service, a Physician or other health care Provider who has a contractual relationship with BCBSIL setting a rate (above which the Provider cannot bill the member) for furnishing such item or service under the Plan, regardless of whether the Provider is considered a preferred or in-network Provider for purposes of in-network or out-of-network benefits under the Plan.

"**Participating Facility**" means, for purposes of this section only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSIL setting a rate (above which the Provider cannot bill the member) for furnishing such item or service under the Plan, regardless of whether the Provider is considered a preferred or in-network Provider for purposes of in-network or out-of-network benefits under the Plan.

"**Qualifying Payment Amount**" means, for purposes of this section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"**Recognized Amount**" means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or Billed Charges.

3. <u>Federal No Surprises Act Surprise Billing Protections</u>

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

a. Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.

b. Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections).

c. Air Ambulance Services received from a Non-Participating Provider if the services would be covered if received from a Participating Provider.

Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider. Additionally, under Illinois law, in the event there is a payment dispute between the Non-Participating Provider and BCBSIL and attempts to negotiate a payment resolution are unsuccessful, the Non-Participating Provider or BCBSIL may initiate binding arbitration.

Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or Billed Charges.

For Included Services, these cost-share requirements will be counted toward your Participating Provider Deductible and/or Out-of-Pocket Limit, if any.

4. Federal No Surprises Act Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill you is your in-network cost-share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

REIMBURSEMENT PROVISION

If you or one of your covered dependents (if you have Family Coverage) incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in this Policy, you agree:

1. Blue Cross and Blue Shield has the right to reimbursement for all benefits Blue Cross and Blue Shield provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which Blue Cross and Blue Shield has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.
2. Blue Cross and Blue Shield is assigned the right to recover from the third party, or his/her insurer, to the extent of the benefits Blue Cross and Blue Shield provided for that sickness or injury.

Blue Cross and Blue Shield shall have the right to first reimbursement out of all funds you, your covered dependents, or your legal representative, are or were able to obtain from the same expenses for which Blue Cross and Blue Shield has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that Blue Cross and Blue Shield may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

AMERICAN INDIAN/ALASKAN NATIVE COST-SHARING NOTICE

This Notice is hereby adopted and incorporated into your Policy. Please read it carefully.

If you are an American Indian/Alaskan Native enrolled under this Policy, the following variations in cost-sharing amounts will apply to your coverage under this Qualified Health Plan (QHP) offered on the Exchange:

If you have a household income of less than 300% of the Federal Poverty Level, you may be eligible for a Zero Cost Sharing (ZCS) Plan.

1. If you are enrolled in a ZCS QHP with a non-participating benefit, you will have your cost-sharing for medical and drug essential health benefits, as defined in this Policy, reduced to zero when the benefit is provided at both Participating and Non-Participating Provider levels. Any Prior Authorization requirements, balance billing/overage from Non-Participating Providers, and any maximum benefit limitation or Exclusions, will still apply.

2. If you are enrolled in a ZCS QHP without a non-participating benefit (e.g., HMO), you will have your cost-sharing for medical and drug essential health benefits, as defined in your benefit booklet, reduced to zero for participating services only. Your ZCS QHP does not provide benefits for services received from a Non-Participating Provider, so you may be responsible for all costs associated for services obtained from such a Provider. Any Prior Authorization requirements, balance billing/overage from Non-Participating Providers, and any maximum benefit limitations or Exclusions, will still apply.

If you are not eligible for a ZCS Plan, you may be eligible for a Limited Cost Sharing (LCS) Plan.

1. Under the LCS plans, you will have cost-sharing for medical and drug essential health benefits, as defined in this Policy, reduced to zero when you receive services from an Indian Health Service Provider, other tribal or urban Indian organization Provider (“I/T/U Providers”), or through a referral issued by an I/T/U Provider under the Contract Health Service (“CHS”) program. If you do not receive services from an I/T/U Provider or through a CHS referral, you may be responsible for cost-sharing described in your benefit materials. Any applicable Prior Authorization requirements, balance billing/coverage from Non-Participating Providers, any maximum benefit limitations or Exclusions, will still apply.

For information on whether a specific Provider is a Participating Provider or Non-Participating Provider or whether a specific Provider is an IHS or other tribal or urban Indian organization Provider, call a customer service representative at the number located on the back of your identification card.

NOTICE OF PROTECTION PROVIDED BY

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay Claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
  - $300,000 for death benefits
  - $100,000 for cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefit plans*
  - $300,000 for disability insurance benefits
  - $300,000 for long-term care insurance benefits
  - $100,000 for other types of health insurance benefits
- Annuities
  - $250,000 for withdrawal and cash values

* The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health Insurance Guaranty Association
901 Warrenville Road, Suite 400
Lisle, Illinois 60532-4324

Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767

Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

(Source: Amended at 43 Ill. Reg. 3290, effective February 25, 2019)

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbsil.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

bcbsil.com IL1557_ENG_20250410

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

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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