BlueCross BlueShield of Illinois

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



Your Health Care Benefits Program

300 East Randolph Street | Chicago, IL 60601-5099
1-800-892-2803

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

State of Illinois

H06802

A message from

BLUE CROSS AND BLUE SHIELD

Your Group has entered into an agreement with us (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 herein called "Blue Cross and Blue Shield" and/or, "BCBSIL") to provide you with this HMO Illinois health care benefit program. In this Certificate, we refer to our company as the "Plan" and we refer to your employer, association or trust as the "Group". The DEFINITIONS section will explain the meaning of many of the terms used in this Certificate. All terms used in this Certificate, when defined in the DEFINITIONS section, begin with a capital letter. Whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER IS AN INDEPENDENT CONTRACTOR, NOT AN EMPLOYEE OR AGENT OF YOUR BLUE CROSS AND BLUE SHIELD HMO. YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER RENDERS AND COORDINATES YOUR MEDICAL CARE. YOUR BLUE CROSS AND BLUE SHIELD HMO IS YOUR BENEFIT PROGRAM, NOT YOUR HEALTH CARE PROVIDER.

Any reference to "applicable law" will include applicable laws and rules, including but not limited to statutes, ordinances, administrative decisions and regulations. We suggest that you read this entire Certificate very carefully. We hope that any questions that you might have about your coverage will be answered here. Should you have any questions regarding the benefits of this Certificate, please contact customer service at the toll-free number on the back of your identification card.

THIS CERTIFICATE REPLACES ANY PREVIOUS CERTIFICATES THAT YOU MAY HAVE BEEN ISSUED BY THE PLAN.

If you have any questions once you have read this Certificate, talk to your Group Administrator or call us at your local Blue Cross and Blue Shield office. It is important to all of us that you understand the protection this coverage gives you.

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

Sincerely,



Brian Snell

President

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BENEFIT HIGHLIGHTS

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

Coverage Services Expense Limitations	
Individual Coverage Services Expense Limitations	$3,000 per calendar year
Family Coverage Services Expense Limitations	$6,000 per calendar year
Physician Benefits	
Your cost for Covered Services (unless specified otherwise below) (Including Mental Illness and Substance Use Disorder Treatment)	None
Your cost for Outpatient office visits (Including Mental Illness and Substance Use Disorder Treatment)	$20 per visit
Your cost for Outpatient Specialist Physician visits	$20 per visit
Your cost for Outpatient office visits for treatment of Mental Illness	$20 per visit
Your cost for Outpatient Specialist Physician visits for treatment of Mental Illness	$20 per visit
Limit on number of Chiropractic and Osteopathic Manipulation visits	None
Your cost for Outpatient Rehabilitative Therapy Treatments	$20 per treatment
Your cost for Outpatient office visits for preventive care services	None
TELEHEALTH AND TELEMEDICINE SERVICES	
Your cost for Telehealth visits	$10 per visit
Your cost for Telehealth visits for treatment of Mental Illness	$10 per visit
Your cost for Telehealth visits for treatment of Substance Use Disorder	$10 per visit
Your cost for Telehealth Specialist Physician visits	$10 per visit
Hospital Benefits	
Your cost for Inpatient Covered Services	$250 per Inpatient admission, then 0% of the Eligible Charge
Your cost for Outpatient Covered Services (Including Mental Illness)	$20 per visit
Your cost for all other Outpatient Covered Services (Including Mental Illness)	None

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Your cost for Outpatient Surgery (Including Mental Illness)	$150 per visit, thereafter 0% of the Eligible Charge
Supplemental Benefits	
Your cost for Covered Services	None
Emergency Care Benefits	
Your cost for an in-area emergency	$200 emergency room Copayment (waived if admitted to Hospital as an Inpatient immediately following emergency treatment)
Your cost for an out-of-area emergency	$200 emergency room copayment (waived if admitted to Hospital as an Inpatient immediately following emergency treatment)
Your cost for emergency ambulance transportation	None
Substance Use Disorder Treatment Benefits	
Your cost for Inpatient Substance Use Disorder Treatment	$250 per Inpatient admission, then 0% of the Inpatient Hospital charges
Your cost for Outpatient office visits for Substance Use Disorder Treatment	$20 per visit
Your cost for Outpatient Specialist Physician office visits for Substance Use Disorder Treatment	$20 per visit

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

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Outpatient Prescription Drug Program Benefits

Please refer to the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS section of your Certificate for additional information regarding how payment is determined. Benefits are available 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 and/or Copayment 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.

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

Tier 1 Generic Drugs, insulin and insulin syringes	$10 per Prescription
Tier 2 Brand Name Drugs (Preferred)	$20 per Prescription
Tier 3 Brand Name Drugs (Non-Preferred) ***for which there is no Generic Drug available***	$40 per Prescription
Tier 3 Brand Name Drugs (Non-Preferred) ***for which there is a Generic Drug available***	$40, plus the difference between the generic and Brand Name Drugs costs per Prescription
Diabetic Supplies	None

Your Cost for Prescription drugs and diabetic supplies purchased from a Prescription Drug Provider not participating in the **34 day supply** Prescription drug program:
The appropriate Copayment(s) indicated above for drugs prescribed for emergency conditions.
Your cost for Prescription drugs and diabetic supplies purchased from a Prescription Drug Provider participating in the **90-day supply** Prescription drug program:

Tier 1 Generic Drugs, insulin and insulin syringes	$25 per Prescription
Tier 2 Brand Name Drugs (Preferred)	$50 per Prescription
Tier 3 Brand Name Drugs (Non-Preferred) ***for which there is no Generic Drug available***	$100 per Prescription
Tier 3 Brand Name Drugs (Non-Preferred) ***for which there is a Generic Drug available***	$100, plus the difference between the generic and Brand Name Drugs costs per Prescription
Diabetic supplies	None

Your cost for Prescription drugs and diabetic supplies purchased from a Prescription Drug Provider not participating in the 90-day supply Prescription Drug Program:
No benefits will be provided for drugs or diabetic supplies purchased from a Participating Prescription Drug Provider not participating in the 90-day supply program.
Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.
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 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.

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* Applies towards the Covered Services expense limitation (see the **OTHER THINGS YOU SHOULD KNOW** section of this Certificate.)

Certain covered drugs may be available at no cost through a Participating Pharmacy for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses and nitrates. For further information, call the number on the back of your identification card.

Select drugs may be covered with no Member cost share, to make these medications more affordable to Member.

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HEARING AID BENEFITS

Hearing Aid benefits

Benefit Period	24 months
Benefit maximum	None
Benefit payment level	100% of Provider's Charge
Number of Hearing Aids, per ear, each Benefit Period	One
LIMITING AGE FOR DEPENDENT CHILDREN	26

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ELIGIBILITY

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

Subject to the other terms and conditions of the Group Policy, the benefits described in this Certificate will be provided to persons who:

1. Meet the definition of an Eligible Person as specified in the Group Policy;
2. Have applied for this coverage;
3. Have received a Blue Cross and Blue Shield identification card;
4. Live within the Plan's service area. (Contact your Group or customer service at 1-800-892-2803 for information regarding service area.);
5. Reside, live or work in the geographic network service area served by Blue Cross and Blue Shield for this Certificate of coverage. You may call customer service at the number shown on the back of your identification card to determine if you are in the network service area or log on to the website at www.bcbsil.com.

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

When your Group initially purchases this coverage and such coverage is purchased as replacement of coverage under another carrier's group policy, those persons who are Totally Disabled on the effective date of this coverage and who were covered under the prior group policy will be considered eligible for coverage under this Certificate.

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

Your dependent children who have reached the limiting age of this Certificate will be considered eligible dependents under this Certificate if they were covered under the prior group policy and, because of a disabling condition, are incapable of self-sustaining employment and are dependent upon you or other care Providers for lifetime care and supervision.

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

APPLYING FOR COVERAGE

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

You can get the application form from your Group Administrator. An application to add a newborn to Family Coverage is not necessary if an additional premium is not required. However, you must notify your Group Administrator within 31 days of the birth of a newborn child for coverage to continue beyond the 31 day period or you will have to wait until your Group's open enrollment period to enroll the child.

The application(s) for coverage may or may not be accepted. Please note, some Employers only offer coverage to their employees, not to their employees' spouses, parties to a Civil Union, Domestic Partners or dependents. In those circumstances, the references in this Certificate to an employee's family members are not applicable.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, Claims experience, receipt of health care, 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 Certificate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Certificate 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 coverage for yourself and/or your eligible spouse and/or dependents during one of the following enrollment periods. Your and/or your eligible spouse and/or dependents' effective date will be determined by the Plan depending upon the date your application is received and other determining factors.

The Plan may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an Eligible Person under this Certificate.

Annual Open Enrollment Periods/Effective Date of Coverage

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

This section “Annual Open Enrollment Periods/Effective Date of Coverage” is subject to change by the Plan, and/or applicable law or regulatory guidance, as appropriate.

SPECIAL ENROLLMENT PERIODS

Special Enrollment Periods/Effective Dates of Coverage

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

You must provide acceptable proof of a qualifying event with your application. Special enrollment qualifying events are discussed in detail below. The Plan 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 the following qualifying events.

Special Enrollment Events:

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

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

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

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

This section “Special Enrollment Periods/Effective Date of Coverage” is subject to change by Plan and/or applicable law or regulatory guidance, as appropriate.

Other Special Enrollment Events/Effective Dates of Coverage:

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

1. Loss of eligibility as a result of:
    a. Legal separation, divorce, or dissolution of a Civil Union or a Domestic Partnership;
    b. Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent child under this Certificate);
    c. Death of an Eligible Person;
    d. Termination of employment, reduction in the number of hours of employment.
2. Loss of coverage through an HMO in the individual market because you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents no longer reside, live or work in the network service area.
3. Loss of coverage through an HMO, or other arrangement, in the group market because you and/or your eligible spouse, party to a Civil Union or Domestic Partner and/or dependents no longer reside, live or work in the network service area, and no other coverage is available to you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents.
4. You incur a Claim that would meet or exceed a lifetime limit on all benefits.
5. Loss of coverage due to a plan no longer offering benefits to the class of similarly situated individuals that include you.
6. Your Employer ceases to contribute towards your or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependent’s coverage (excluding COBRA continuation coverage).
7. COBRA continuation coverage is exhausted.

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

This section “Other Special Enrollment Periods/Effective Date of Coverage” is subject to change by the Plan and/or applicable law or regulatory guidance, as appropriate.

NOTIFICATION OF ELIGIBILITY CHANGES

It is the Eligible Person's responsibility to notify the Plan of any changes to an Eligible Person's name or address or other changes to eligibility. Such changes may result in coverage/benefit changes for you and your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents. For example, if you move out of the Plan's “network service area”. You must reside, live or work in the geographic “network service area” designated by the Plan. You may call the customer service number shown on the back of your identification card to determine if you live in the network service area or log on to the website at www.bcbsil.com.

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INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

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

NOTE: If you are an employee of the Group who meets 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.

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

1. Live within the network service area of the Plan network for this Certificate; 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.

Coverage for children will end on the last day of the calendar month in which the limiting age birthday falls.

If you have Eligible Dependents, newborn children will be covered from the moment of birth. Please notify the Plan within 31 days of the birth so that your membership records can be adjusted and coverage to continue. Your Group Administrator can tell you how to submit the proper notice through the Plan.

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

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

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

Coverage under this Certificate is contingent upon timely receipt by the Plan of necessary information and initial premium.

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MEDICARE ELIGIBLE ENROLLEE

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

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan (“GHP”) coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

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

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

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

Please see your employer or group administrator if you have any questions regarding the ESRD Primary Period or any other provisions of the MSP laws and their application to you, your spouse or your dependents.

Your MSP Responsibilities

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

YOUR IDENTIFICATION CARD

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

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

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

1. Marriage.

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

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3. Obtaining legal guardianship of a child.
4. The establishment of a Domestic Partnership.
5. Becoming party to a Civil Union.
6. Loss of eligibility for other health coverage for you or your dependent if:
    a. The other coverage was in effect when you were first eligible to enroll for this coverage;
    b. The other coverage is not terminating for cause (such as failure to pay premiums or mailing a fraudulent Claim); and
    c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

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

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

WHEN COVERAGE BEGINS

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

1. Marriage.
2. Birth, adoption or placement for adoption of a child.
3. Obtaining legal guardianship of a child.
4. The establishment of a Domestic Partnership.
5. Becoming party to a Civil Union.
6. Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.

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

8. Exhaustion of COBRA continuation or state continuation coverage.

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

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

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

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

You can get the application form from your Group Administrator. However, an application to add a newborn to Family Coverage is not necessary if an additional premium is not required. Please notify your Group Administrator so that your membership records can be adjusted.

LATE APPLICANTS

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

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

You can apply to change from Family to Individual Coverage at any time. Your Group Administrator will give you the application and tell you the date that the change will be effective. Premiums will be adjusted accordingly.

TERMINATION OF COVERAGE

If the Plan terminates your coverage under this Certificate for any reason, the Plan will provide you with a notice of termination of coverage that includes the termination effective date and the reason for termination at least 30 days prior to the last day of coverage, except as otherwise provided in this Certificate.

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

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

2. When the Plan does not receive the full amount of the premium payment or other charge or amount on time or when there is a bank draft failure of premiums for your and/or your eligible spouse, party to a Civil Union or Domestic Partner and/or dependents' coverage and the grace period, if any, has been exhausted.

3. You no longer live, reside or work in the Plan's service area or live, reside or work in the network service area.

4. Your coverage has been rescinded.

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

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

7. The entire coverage of your Group terminates.

Termination of your Group's Policy automatically terminates your coverage under this Certificate. It is your Group's responsibility to inform you of the termination of the Group Policy but your coverage will be terminated regardless of whether or not such notice is given.

Termination of a Dependent's Coverage

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

Reinstatement

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

WHO IS NOT ELIGIBLE

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

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

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

This section "WHO IS NOT ELIGIBLE" is subject to change by the Plan and/ or applicable law or regulatory guidance, as appropriate.

Extension of Benefits in Case of Discontinuance of Coverage

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

1. Outpatient Prescription Drug Program Benefits

2. Hearing Aid Benefits

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA provision does not apply to your Domestic Partner and their children.

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

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Introduction

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

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

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

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

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

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

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

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

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

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than their gross misconduct;
4. The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);

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5. The parents become divorced or legally separated; or

6. The child stops being eligible for coverage under the Plan as a “dependent child.”

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the

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18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

COVERAGE AFTER TERMINATION (Illinois State Laws)

This COVERAGE AFTER TERMINATION provision does not apply to Domestic Partners and their children.

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the Eligible Person (as specified in the Group Policy) at the time of termination. The provisions described in Article B will apply if you are the spouse of a retired Eligible Person or the party to a Civil Union with a retired Eligible Person and are at least 55 years of age or the former spouse of an Eligible Person or the former party to a Civil Union with a retired Eligible Person who has died or from whom you have been divorced or from whom your Civil Union has been dissolved. The provisions described in Article C will apply if you are the dependent child of an Eligible Person who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided under Article B.

Your continued coverage under this Certificate will be provided only as specified below. Therefore, after you have determined which Article applies to you, please read the provisions very carefully.

ARTICLE A: Continuation coverage if you are the Eligible Person

If an Eligible Person's coverage under this Certificate should terminate because of termination of employment or membership or because of a reduction in hours below the minimum required for eligibility, an Eligible Person will be entitled to continue the Hospital, Physician and Supplemental coverage provided under this Certificate for themselves and their eligible

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dependents (if he/she had Family Coverage on the date of termination). However, this continuation coverage option is subject to the following conditions:

1. Continuation coverage will be available to you only if you have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least 3 months prior to your termination date or reduction in hours below the minimum required for eligibility.

2. Continuation coverage will not be available to you if: (a) you are covered by Medicare or (b) you have coverage under any other health care program which provides group Hospital, surgical or medical coverage and under which you were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility, or (c) you decide to become a member of the Plan on a “direct pay” basis.

3. Within 10 days of your termination of employment or membership or reduction in hours below the minimum required for eligibility, your Group will provide you with written notice of this option to continue your coverage. If you decide to continue your coverage, you must notify your Group, in writing, no later than 30 days after your coverage has terminated or reduction in hours below the minimum required for eligibility or 30 days after the date you received notice from your Group of this option to continue coverage. However, in no event will you be entitled to your continuation coverage option more than 60 days after your termination or reduction in hours below the minimum required for eligibility.

4. If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by the Plan for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to the Plan (by your Group) on a monthly basis, in advance, for the entire period of your continuation coverage under this Certificate.

5. Continuation coverage under this Certificate will end on the date you become eligible for Medicare, become a member of the Plan on a “direct pay” basis or become covered under another health care program (which you did not have on the date of your termination or reduction in hours below the minimum required for eligibility) which provides group Hospital, surgical or medical coverage. However, your continuation coverage under this Certificate will also end on the first to occur of the following:

    a. Twelve months after the date the Eligible Person's coverage under this Certificate would have otherwise ended because of termination of employment or membership or reduction in hours below the minimum required for eligibility.

    b. If you fail to make timely payment of required charges, coverage will terminate at the end of the period for which your charges were paid.

    c. The date on which the Group Policy is terminated. However, if this Certificate is replaced by similar coverage under another group policy, the Eligible Person will have the right to become covered under the new coverage for the amount of time remaining in the continuation coverage period.

ARTICLE B: Continuation Coverage if you are the former spouse of an Eligible Person or spouse of a retired Eligible Person

If the coverage of the spouse of an Eligible Person should terminate because of the death of the Eligible Person, a divorce from the Eligible Person, dissolution of a Civil Union from the Eligible Person, or the retirement of an Eligible Person, the former spouse or retired Eligible Person's spouse if at least 55 years of age, will be entitled to continue the coverage

provided under this Certificate for themselves and their eligible dependents (if Family Coverage is in effect at the time of termination). However, this continuation coverage option is subject to the following conditions:

1. Continuation will be available to you as the former spouse of an Eligible Person or spouse of a retired Eligible Person only if you provide the employer of the Eligible Person with written notice of the dissolution of marriage or Civil Union, the death or retirement of the Eligible Person within 30 days of such event.

2. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to the Plan of the dissolution of your marriage or Civil Union to the Eligible Person, the death of the Eligible Person or the retirement of the Eligible Person as well as notice of your address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents under this Certificate may be continued. The Plan's notice to you will include the following:

   a. a form for election to continue coverage under this Certificate.

   b. notice of the amount of monthly charges to be paid by you for such continuation coverage and the method and place of payment.

   c. instructions for returning the election form within 30 days after the date it is received from the Plan.

3. In the event you fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Eligible Person under this Certificate as a result of the dissolution of marriage or Civil Union, the death or the retirement of the Eligible Person. Your right to continuation coverage will then be forfeited.

4. If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all Eligible Persons under this Certificate.

5. If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:

   a. an amount, if any, that would be charged to you if you were an Eligible Person, with Individual or Family Coverage, as the case may be, plus;

   b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

   Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate your continuation benefits and the right to continuation coverage.

6. If you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.

7. Termination Continuation Coverage:

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If you have not reached age 55 at the time your continued coverage begins, your continuation coverage shall end on the first to occur of the following:

a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

b. on the date coverage would otherwise terminate under this Certificate if you were still married to or in a Civil Union with the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.

c. the date on which you remarry or enter another Civil Union.

d. the date on which you become an insured employee under any other group health plan.

e. the expiration of 2 years from the date your continued coverage under this Certificate began.

8. If you have reached age 55 at the time your continued coverage begins, your continuation coverage shall end on the first to occur of the following:

a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

b. on the date coverage would otherwise terminate, except due to the retirement of the Eligible Person under this Certificate if you were still married to or in a Civil Union with the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death, retirement or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.

c. the date on which you remarry or enter another Civil Union.

d. the date on which you become an insured employee under any other group health plan.

e. the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.

9. If you exercise the right to continuation coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.

10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation coverage is in effect, the new insurer must offer continuation coverage to you under the same terms and conditions described in this Certificate.

ARTICLE C: Continuation Coverage if you are the dependent child of an Eligible Person

If the coverage of a dependent child should terminate because of the death of the Eligible Person and the dependent child is not eligible to continue coverage under ARTICLE B or the dependent child has reached the limiting age under this Certificate, the dependent child will be entitled to continue the coverage provided under this Certificate for themselves. However, this continuation coverage option is subject to the following conditions:

1. Continuation will be available to you as the dependent child of an Eligible Person only if you, or a responsible adult acting on your behalf as the dependent child, provide the employer of the Eligible Person with written notice of the death of the Eligible Person within 30 days of the date the coverage terminates.

2. If continuation coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the Eligible Person with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

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3. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to the Plan of the death of the Eligible Person or of the dependent child reaching the limiting age, as well as notice of the dependent child's address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. The Plan's notice to you will include the following:

    a. a form for election to continue coverage under this Certificate.

    b. notice of the amount of monthly charges to be paid by you for such continuation coverage and the method and place of payment.

    c. instructions for returning the election form within 30 days after the date it is received from the Plan.

4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a dependent child of an Eligible Person under this Certificate as a result of the death of the Eligible Person or the dependent child attaining the limiting age. Your right to continuation coverage will then be forfeited.

5. If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all Eligible Persons under this Certificate.

6. The monthly charge will be computed as follows:

    a. an amount, if any, that would be charged to you if you were an Eligible Person, plus;

    b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

    Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate your continuation benefits and the right to continuation coverage.

7. Continuation Coverage shall end on the first to occur of the following:

    a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

    b. on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the Eligible Person.

    c. the date on which you become an insured employee, after the date of election, under any other group health plan.

    d. the expiration of 2 years from the date your continued coverage under this Certificate began.

8. If you exercise the right to continuation coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.

9. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation coverage is in effect, the new insurer must offer continuation coverage to you under the same terms and conditions described in this Certificate.

Other options that may be available for continuation coverage are explained in the Continuation Coverage sections of this Certificate.

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CONTINUATION COVERAGE FOR PARTIES TO A CIVIL UNION

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

Continuation Coverage

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

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

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

If you are a dependent who is a party to a Civil Union or their child and you lose coverage under this Certificate, the options available to a spouse or to a dependent child are described in the CONTINUATION COVERAGE AFTER TERMINATION (Illinois State Laws) provision of this Certificate.

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

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YOUR PRIMARY CARE PHYSICIAN

YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER IS AN INDEPENDENT CONTRACTOR, NOT AN EMPLOYEE OR AGENT OF YOUR BLUE CROSS AND BLUE SHIELD HMO. YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER RENDERS AND COORDINATES YOUR MEDICAL CARE. YOUR BLUE CROSS AND BLUE SHIELD HMO IS YOUR BENEFIT PROGRAM, NOT YOUR HEALTH CARE PROVIDER.

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

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

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

TO BE ELIGIBLE FOR THE BENEFITS OF THIS CERTIFICATE, THE SERVICES THAT YOU RECEIVE MUST BE PROVIDED BY OR ORDERED BY YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER.

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

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

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

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

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

You may change your choice of Primary Care Physician or Woman's Principal Health Care Provider to one of the other Physicians in your Participating IPA or Participating Medical Group by notifying your Participating IPA/Participating Medical Group of your desire to change. Contact your Participating IPA/Participating Medical Group, your Primary Care Physician

or Woman's Principal Health Care Provider or the Plan to obtain a list of Providers with whom your Primary Care Physician and/or Woman's Principal Health Care Provider have a referral arrangement.

Changing Your Participating IPA/Participating Medical Group

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

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

When necessary, Participating IPAs/Participating Medical Groups have the right to request the removal of members from their enrollment. Their request cannot be based upon the type, amount or cost of services required by any member. If the Plan determines that the Participating IPA/Participating Medical Group has sufficient cause and approves such a request, such members will be offered enrollment in another Participating IPA or Participating Medical Group or enrollment in any other health care coverage then being provided by their Group, subject to the terms and conditions of such other coverage. The change will be effective no later than the first day of the month following 45 days from the date the request is received.

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

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

Changing Your Woman's Principal Health Care Provider

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

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

After-Hours Care

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

Transition of Care Benefits

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

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If you are a current HMO Enrollee and you are receiving care for a condition that requires an ongoing course of treatment or if you have entered into the second or third trimester of pregnancy and your Primary Care Physician or Woman's Principal Health Care Provider leaves the Plan's network, you may request the option of Continuity of Care benefits as described in the Continuity of Care provision in the OTHER THINGS YOU SHOULD KNOW section. You must submit a written request to the Plan for continuity of care benefits within 30 business days after receiving notification of your Primary Care Physician or Woman's Principal Health Care Provider's termination.

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

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

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

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PHYSICIAN BENEFITS

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

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

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

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

A1C Testing

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

Allergy Testing and Treatment

Alzheimer’s Disease and Related Dementias

This plan provides benefits for medically necessary FDA-approved treatments or medications to slow the progression of Alzheimer’s Disease or related dementias, as determined by a Physician.

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.

Approved Clinical Trials

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

Autism Spectrum Disorder(s)

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) for persons under 21 years of age are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) your Primary Care Physician or Woman's Principal Health Care Provider who has determined that such care is medically necessary, or (b) a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder(s) and when the care is determined to be medically necessary and ordered by your Primary Care Physician or Woman's Principal Health Care Provider:

1. psychiatric care, including diagnostic services;
2. psychological assessment and treatment;
3. habilitative or rehabilitative treatment;
4. therapeutic care, including behavioral Occupational Therapy, Physical Therapy and Speech Therapy that provide treatment in the following areas:

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

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

Biomarker Testing

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

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. This coverage also includes related supplies, and training in the use of continuous glucose monitors.

Benefits for glucose monitors, including one transmitter, will be provided at no charge when obtained from a Participating Pharmacy.

Bone Mass Measurement and Osteoporosis

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

Breast Cancer Pain Medication

Benefits will be provided for all medically necessary pain medication and pain therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically based and includes reasonably defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

Breast Reduction Surgery

This plan provides benefits for medically necessary breast reduction surgery.

Cardiac Rehabilitation Services

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

Chemotherapy

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

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.

Cleft Lip and Palate

Benefits will be provided for medically necessary treatment and care for cleft lip and palate for children under the age of 19.

Comprehensive Cancer Testing

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

Consultations — that is, examination and/or treatment by a Physician to obtain their advice in the diagnosis or treatment

of a condition which requires special skill or knowledge.

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

Diabetes Self-Management Training and Education

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

Diagnostic Colonoscopies

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

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

Early Treatment of Serious Mental Illness

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

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.

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

Epinephrine Injectors — Unless otherwise provided for in this Certificate, benefits for medically necessary epinephrine injectors are available under this benefit section.

Experimental/Investigational Treatment

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

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

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

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

Fertility Preservation Services

Benefits will be provided for medically necessary Standard Fertility Preservation Services when a necessary medical treatment may directly or indirectly cause Iatrogenic Infertility to a member. Coverage determinations for these benefits will

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not be affected by your expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, or marital status.

Fibrocystic Breast Condition

Benefits will be provided for Covered Services related to fibrocystic breast condition.

Hearing Implants

This plan provides benefits for bone anchored hearing aid (cochlear implants).

Hearing Screening — when done to determine the need for hearing correction.

HIV Screening and Counseling

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

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/birthing parent is medically or physically unable to produce breast milk or produce breast milk in sufficient quantities to meet the infant’s needs or the mother/birthing parent’s 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/birthing parent is medically or physically unable to produce breast milk or produce breast milk in sufficient quantities to meet the infant’s needs or the mother/birthing parent breast milk is contraindicated;

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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.

Immune Gamma Globulin Therapy (IGGT)

Benefits will be provided for immune gamma globulin therapy for covered persons diagnosed with a primary immunodeficiency when prescribed as medically necessary by the Primary Care Physician or Woman's Principal Health Care Provider. Nothing shall prevent Blue Cross and Blue Shield or its designee from applying appropriate utilization review standards to the ongoing coverage of IGGT for person 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.

Infertility Diagnosis and Treatment of Other Medical Conditions

Benefits will be provided for the diagnosis of infertility and the treatment of medical conditions which may directly cause infertility.

Infertility Diagnosis and Treatment

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

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

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

Infertility means 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 an individual 35 years of age or younger, or after 6 months for an individual over 35 years of age (conceiving but having a miscarriage does not restart the 12 month or 6-month term for determining Infertility).
2. A person's inability to reproduce either as a single individual or with a partner without medical intervention, or
3. A licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Unprotected sexual intercourse means sexual union between a male and a female, without the use of any process, device

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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 renders such treatment useless. Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per calendar year, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals will be covered. These benefits include other medically necessary fertility services until you or your surrogate is discharged to regular obstetrical care.

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

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

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

1. Services or supplies rendered to a surrogate, after eggs, sperm or embryos have been transferred into the surrogate, non-medical expenses you incur to contract with the surrogate, and any other services rendered to a surrogate that are not directly related to treatment of your infertility.

2. Cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance. Please note that benefits may be provided for fertility preservation as set forth in the Fertility Preservation provision of this Certificate.

3. Non-medical costs of an egg or sperm donor.

4. Travel costs for travel within 100 miles of the Enrollee's home or which is not medically necessary, or which is not required by the Plan.

5. Infertility treatments which are determined to be Investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology.

6. Infertility treatment rendered to your dependents under the age of 18.

7. Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of “Infertility” as stated above.

Inherited Gene Mutation Testing

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

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

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

Long-Term Antibiotic Therapy

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

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

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

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
2. an annual mammogram

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

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

Diagnostic Mammograms

Benefits for Diagnostic Mammograms will be provided when determined to be medically necessary by your Primary Care Physician, Woman's Principal Health Care Provider, Advanced Practice Nurse, or Physician Assistant.

Benefits for mammograms will be provided at 100% of the Provider's Charge, whether or not you have met your program deductible, and will not be subject to any benefit period maximum or lifetime maximum.

In addition to the definitions of this Certificate, the following definitions are applicable to this provision:

Diagnostic Mammograms means a mammogram obtained using Diagnostic Mammography.

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

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

Mastectomy Related Services

Benefits will be provided for Covered Services related to mastectomies, including, but not limited to,

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

3. Post mastectomy care for Inpatient treatment for a length of time determined by the attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation, and a follow-up Physician office visit or in-home nurse visit within forty-eight (48) hours after discharge;

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

5. The removal of breast implants when the removal of the implants is a medically necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered unless medically necessary. Cosmetic changes performed as reconstruction resulting from sickness or injury are not considered cosmetic Surgery.

Medical Benefit Therapeutic Alternatives

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

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

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

Menopause Health Visit

Benefits will be provided for an annual menopause health visit at no charge.

Mental Illness and Substance Use Disorder Treatment

Benefits will be provided for medically necessary Mental Illness and Substance Use Disorder Treatment. 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.

Note: Prior Authorization is not required for Inpatient treatment services for Mental Illness, when obtained from a Participating Hospital; or for Inpatient or Outpatient Substance Use Disorders, when obtained from a Participating Provider.

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.

Orthotic Devices

This plan provides benefits for a medically necessary 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 you 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.

Note: Standard (in-shoe) foot orthotics are covered up to a maximum of two devices or one pair per calendar year. This

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limitation does not apply to customized orthotic devices.

Other Reproductive Health Services

Your coverage includes benefits for abortion care. Benefits for abortion care will be provided at no cost, and will not be subject to any coverage restrictions or delays.

Outpatient Contraceptive Services

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

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

Contraceptive Drugs

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

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

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

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

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

You, your prescribing health care Provider (your “prescriber”) or your authorized representative, can ask for the Drug List or the Contraceptive Coverage List exception if your drug is not on (or is being removed from) the Drug List or the Contraceptive Coverage List or dispensing limit has been found to be (or is likely to be) not right for you or does not work as well in treating your condition. To request this exception, you, your prescriber or authorized representative can call the number on the back of your identification card to ask for a review. Blue Cross and Blue Shield will let you, your prescriber or authorized representative know the coverage decision within 72 hours after they receive your request. If the coverage request is denied, Blue Cross and Blue Shield will let you, your prescriber or authorized representative know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial.

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

Outpatient Periodic Health Examinations — including the taking of your medical history, physical examination, and any diagnostic tests necessary because of your age, sex, medical history or physical condition. You are eligible for these

examinations as often as your Primary Care Physician or Woman's Principal Health Care Provider, following generally accepted medical practice, finds necessary.

Covered Services include, but are not limited to:

1. Clinical breast examinations;

2. Routine cervical smears or Pap smears;

3. Routine prostate- specific antigen tests and digital rectal examinations;

4. Colorectal cancer screening — as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology; and

5. Ovarian cancer screening — using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

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

Outpatient Respiratory Therapy — when rendered for the treatment of an illness or injury by or under the supervision of a qualified respiratory therapist.

Outpatient Speech Therapy for Pervasive Developmental Disorders.

Benefits will be provided for Outpatient Speech Therapy visits for pervasive developmental disorders as determined by your Primary Care Physician or Woman's Principal Health Care Provider.

Pancreatic Cancer Screening

Benefits will be provided for medically necessary pancreatic cancer screenings.

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.

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.

Physical Therapy

This plan provides benefits for medically necessary Physical Therapy when:

1. Rendered by a Physician or physical therapist; and

2. If the therapy is beyond the scope of the physical therapists license, the physical therapist must be under the supervision of a Physician. The Physical Therapy must also be furnished under a written plan established by a Physician and reviewed on a regular basis by the physical therapist and the Physician.

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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 an anticipated goals, Benefits will also be provided for preventive Physical Therapy when prescribed for persons affected by multiple sclerosis. Benefits for Autism spectrum Disorder will not apply towards and are not subject to any Physical Therapy visit maximums, if any, shown in the Summary of Benefits section under this Certificate.

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.

Prenatal Vitamins

Benefits will be provided for prenatal vitamins, when prescribed by your Primary Care Physician or Woman's Principal Health Care Provider

Prostate Cancer Screening

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

Prosthetic Appliances

This plan provides benefits for medically necessary prosthetic devices including those determined by your Provider to be the most appropriate for physical activities, such as running, biking, swimming, and lifting, special appliances and surgical implants when:

1. They are required to replace all or part of an organ or tissue of the human body; or

2. They are required to replace all, or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required, because of wear or change in a patient’s condition excluding:

1. Dental appliances other than intro-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related disorders, subject to specific limitations applicable to temporomandibular join dysfunction and related disorders; and

2. Replacement of cataract lenses (when a prescription change is not required).

Pulmonary Rehabilitation Therapy

Benefits will be provided for Outpatient cardiac/pulmonary rehabilitation programs and Outpatient pulmonary rehabilitation services.

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

Reconstructive Services

This plan provides benefits for medically necessary reconstructive services to restore physical appearance due to trauma.

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.

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

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

Routine Vision Examinations

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

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

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

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

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

1. Surgical removal of completely bony impacted teeth;
2. Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth;
3. Surgical procedures to address major injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth, due to accident or disease; (including dental implants, crowns, or bridges; prosthetic treatment; and orthodontic, prosthodontic, and otolaryngology treatment and management);
4. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses (s);
5. Treatment of fractures of facial bone;
6. External incision and drainage of cellulitis;
7. Incision of accessory sinuses, salivary glands or ducts; and
8. Reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

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

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

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

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

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

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

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 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.

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

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

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

5. Medical Care

Benefits will be provided for Medical Care rendered to you:

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

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

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

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

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

Telehealth and Telemedicine Services

Telehealth and Telemedicine Services are covered, as described in the BENEFIT HIGHLIGHTS section of this Certificate.

Temporomandibular Joint Dysfunction and Related Disorders

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

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.

Tobacco Use Cessation Drugs

Tobacco Use Screening and Smoking Cessation Counseling Services

Vaginal Estrogen

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

Vitamin D Testing

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

Wigs: This plan provides benefits for one wig every 12 months(also referred to as a scalp prostheses) for hair loss caused by :

1. Chemotherapy;
2. Radiation therapy; or
3. Alopecia.

Preventive Care Services

In addition to the benefits otherwise provided in this Certificate, (and notwithstanding anything in your Certificate to the contrary), the following preventive care services when ordered by your Primary Care Physician or Woman's Principal Health Care Provider and will not be subject to any deductible, Coinsurance, Copayment or benefit dollar maximums, if any, as shown elsewhere in this Certificate, such as in the BENEFIT HIGHLIGHTS section (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 in item 1. above, as provided for in comprehensive guidelines supported by the HRSA.

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

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

The preventive care services described in items 1 through 4 above may changeas USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Blue Cross and Blue Shield web site at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

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If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, the Plan 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 the Copayment for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment for the office visit including the preventive health service.

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

1. Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked;
2. 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 45;
7. Counseling children, adolescents, and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
8. Depression screening;
9. Exercise intervention to prevent falls in adults age 65 years and older who are at increased risk for falls;
10. Hepatitis B virus screening for persons at high risk for infection;
11. Hepatitis C virus (HCV) screening infection in adults aged 18 to 79 years;
12. HIV preexposure prophylaxis ((PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition, including baseline and monitoring services;
13. HIV screening for all adults at higher risk;
14. 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;
15. Lung cancer screening in adults 50 and older who have a 20-pack year smoking history and currently smoke or have quit within the past 15 years;
16. Mental health prevention and wellness visit.
17. Obesity screening and counseling;
18. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease;
19. Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese;

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

21. Sexually transmitted infections (STI) counseling;

22. Syphilis screening for adults at higher risk;

23. The following immunization vaccines for adults (doses, recommended ages,and recommended populations vary):

a. COVID-19;

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. Tetanus, Diphtheria, Pertussis (DTap/Tdap/Td); and

n. Varicella

24. Tobacco use screening and cessation interventions for Tobacco Users;

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

26. Unhealthy alcohol and drug use screening and counseling; and

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

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

1. Aspirin use for pregnant persons to prevent preeclampsia;

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

3. Behavioral counseling to maintain weight or limit weight gain to prevent obesity for women who are aged 40 or older;

4. Behavioral counseling to promote healthy weight gain during pregnancy;

5. Counseling about genetic testing for women at higher risk (including BRCA 1 \ 2 gene mutations) and if recommended by a Provider after counseling, genetic testing;

6. Breast cancer chemoprevention counseling for women at higher risk;

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7. Breast cancer mammography screening, including breast tomosynthesis and, if determined to be medically necessary by your Primary Care Physician, Woman's Principal Health Care Provider, Advanced Practice Nurse, or Physician Assistant, a screening MRI and comprehensive ultrasound;

8. Breastfeeding comprehensive lactation support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Electric breast pumps are limited to one per calendar year;

9. Cervical cancer screening;

10. Chlamydia infection screening for younger women and women at higher risk;

11. Condoms;

12. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling;

13. Diabetes screening after pregnancy;

14. Daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant;

15. Domestic and interpersonal violence screening and counseling for all women;

16. Gestational diabetes screening for persons after 24 weeks pregnant and those at high risk of developing gestational diabetes;

17. Gonorrhea screening for all women;

18. Hepatitis B screening for pregnant persons at their first prenatal visit;

19. HIV screening and counseling for all women;

20. 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;

21. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence and device removal;

22. Menopause health visit;

23. Osteoporosis screening for women over age 65, and younger women with risk factors;

24. Perinatal depression screening and counseling;

25. Rh incompatibility screening for all pregnant women and follow- up testing for women at higher risk;

26. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened;

27. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy;

28. Sexually transmitted infections (STI) counseling;

29. Syphilis screening for all pregnant women or other women at increased risk;

30. Tobacco use screening and interventions for all women, and expanded counseling for pregnant Tobacco Users;

31. Urinary incontinence screening; and

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32. Well-woman visits to obtain recommended preventive services.

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

1. Alcohol and drug use assessment for adolescents;
2. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision;
3. Autism screening;
4. Behavioral assessments for children of all ages;
5. Bilirubin screening in newborns;
6. Blood pressure screenings for children of all ages;
7. Cervical dysplasia screening for sexually active females;
8. Congenital hypothyroidism screening for newborns;
9. Critical congenital heart defect screening for newborns;
10. Depression screening for adolescents;
11. Development screening for children under age 3, and surveillance throughout childhood;
12. Dyslipidemia screening for children ages 9-11 and 17-21;
13. Fluoride chemoprevention supplements for children without fluoride in their water source;
14. Fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption;
15. Gonorrhea preventive medication for the eyes of all newborns;
16. Hearing screening for all newborns, children and adolescents;
17. Height, weight and body mass index measurements;
18. Hematocrit or hemoglobin screening;
19. Hemoglobinopathies or sickle cell screening for all newborns;
20. HIV screening for adolescents at higher risk;
21. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    a. COVID-19,
    b. Diphtheria, Tetanus, Pertussin (DTap/Tdap/Td);
    c. Haemophilus influenzae type b (Hib);
    d. Hepatitis A;
    e. Hepatitis B;

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f. Human papillomavirus (HPV);

g. Inactivated Poliovirus Vaccine;

h. Influenza (Flu shot or Flu mist);

i. Measles, Mumps, Rubella;

j. Meningococcal;

k. Pneumococcal;

l. RSV;

m. Rotavirus; and

n. Varicella.

22. Lead screening for children at risk for exposure;

23. Medical history for all children throughout development;

24. Mental Health prevention and wellness visit;

25. Newborn blood screening;

26. Obesity screening and counseling;

27. Oral health risk assessment for younger children up to six years old;

28. Phenylketonuria (PKU) screening for newborns;

29. Sexually transmitted infections (STI) prevention and counseling for adolescents;

30. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents;

31. Tuberculin testing for children at higher risk of tuberculosis;

32. Vision screening for children and adolescents; and

33. Whole body skin examination for lesions suspicious for skin cancer;

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

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

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

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myprime.com to obtain a Copay waiver form.

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 Certificate, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums, if any, as shown elsewhere in this Certificate, such as in the BENEFIT HIGHLIGHTS section. The *Contraceptive Coverage List* and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

URGENT CARE

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

Your Cost for Urgent Care Treatment

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

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

FOLLOW-UP CARE

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

Your Cost for Follow-Up Care Treatment

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

YOUR COST FOR PHYSICIAN SERVICES

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

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

1. Chiropractic and osteopathic manipulation;
2. Outpatient periodic health examinations;
3. Preventive care services;
4. Routine pediatric care;
5. Maternity services after the first pre-natal visit;

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6. Diagnostic Colonoscopies; and

7. Routine vision examinations.

The Covered Services of this benefit section are covered in full, with no cost to you, except as follows:

Benefits for Inpatient Medical Care are subject to a Copayment of $250 per visit and then will be paid in full.

Benefits for Outpatient visits for rehabilitative therapy are subject to a Copayment of $20 per treatment and then will be paid in full. Such Copayment will be waived if the therapy is obtained in a Physician's office.

Benefits for Outpatient visits, except for the treatment of Mental Illness to a Specialist Physician's office are subject to a Copayment of $20 per visit and then will be paid in full whether or not authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

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

1. Physician

2. Physician Assistant

3. Certified Nurse Midwife

4. Certified Nurse Practitioner

5. Certified Registered Nurse Anesthetist

6. Certified Clinical Nurse Specialist

7. Marriage and Family Therapist

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HOSPITAL BENEFITS

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

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

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

COVERED SERVICES

Inpatient Benefits

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

1. **Bed, board and general nursing care** when you are in:

   a. a semi-private room or a private room - must be ordered by your Primary Care Physician or Woman's Principal Health Care Provider.

   b. an intensive care unit.

2. **Ancillary services** (such as operating rooms, drugs, surgical dressings and lab work).

3. **Rehabilitative Therapy** (including, but not limited to Physical, Occupational and Speech Therapy).

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

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

Number of Inpatient Days

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

Outpatient Benefits

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

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

2. **Diagnostic Services** — that is, tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury.

3. **Radiation Therapy** — that is, the use of ionizing radiation in the treatment of a medical illness or condition, including proton beam therapy.

4. **Chemotherapy** — that is, the treatment of malignancies with drugs.

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5. **Electroconvulsive Therapy**

6. **Renal Dialysis Treatments and Continuous Ambulatory Peritoneal Dialysis Treatment** — when received in a Hospital or a Dialysis Facility. Benefits for treatment in your home are available if you are homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and are rendered under the supervision of a Hospital or Dialysis Facility healthcare professional.

Special Programs

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

1. **Coordinated Home Care Program**

2. **Pre-Admission Testing —** This is a program in which preoperative tests are given to you as an Outpatient in a Hospital to prepare you for Surgery that you are scheduled to have as an Inpatient.

3. **Partial Hospitalization Treatment Program —** This is a therapeutic treatment program in a Hospital for patients with Mental Illness.

4. **Tobacco Use Cessation Program.**

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

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

Autism Spectrum Disorder(s) — Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) for persons under 21 years of age are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) your Primary Care Physician or Woman's Principal Health Care Provider who has determined that such care is medically necessary, or (b) a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder(s) when the care is determined to be medically necessary and ordered by your Primary Care Physician or Woman's Principal Health Care Provider:

1. psychiatric care, including diagnostic services;

2. psychological assessment and treatment;

3. habilitative or rehabilitative treatment;

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

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Habilitative Services — Your benefits for Habilitative Services for persons under 19 years of age are the same as your benefits for any other condition if all of the following conditions are met:

1. a Physician has diagnosed the Congenital, Genetic or Early Acquired Disorder; and

2. treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker or Psychologist upon the referral of your Primary Care Physician or Woman's Principal Health Care Provider; and

3. treatment must be medically necessary and therapeutic and not Investigational.

Surgical Implants

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

Maternity Services

Your benefits for services rendered in connection with pregnancy are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. In addition to all of the previously described Covered Services, routine Inpatient nursery charges for the newborn child are covered, even under Individual Coverage. If the newborn child needs treatment for an illness, injury, congenital defect (including medically necessary treatment of cleft lip and palate), birth abnormalities and premature birth, benefits will be available for that care only if you have family coverage. You may apply for family coverage within 31 days of date of the birth. Your family coverage will then be effective from the date of the birth. Premiums will be adjusted accordingly.

Coverage will be provided for the mother/birthing parent and the newborn for a minimum of:

1. 48 hours of Inpatient care following a vaginal delivery, or

2. 96 hours of Inpatient care following a delivery by caesarean section, except as may be indicated by the following: A shorter length of Hospital Inpatient stay related to maternity and newborn care may be provided if the attending Physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or by the American Academy of Pediatrics, that the mother/birthing parent and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother/birthing parent and newborn. Such an earlier discharge may only be required if there is coverage and availability of a post-discharge Physician office visit or an in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

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

Note: If your Provider determines you are experiencing a high-risk pregnancy, you will have access to clinically- appropriate case management programs. This includes, but is not limited to, individual assessment, planning, referral, monitoring, and assistance with access to appropriate health, social, and educational services.

Alternative benefits will be provided only so long as it has been determined that the alternative services are medically necessary. 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.

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Other Reproductive Services

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

URGENT CARE

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

Your Cost for Urgent Care Treatment

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

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

FOLLOW-UP CARE

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

Your Cost for Follow-Up Care Treatment

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

BENEFIT PAYMENT FOR HOSPITAL SERVICES

When you received Covered Services from Coordinated Home Care, kidney dialysis and Infusion Therapy, they will be provided at 100% of the Provider’s Charge.

Each time you are admitted as an Inpatient to a Hospital, Skilled Nursing Facility or Residential Treatment Center, you are responsible for paying a Copayment of $250 per Inpatient admission. After the Copayment, you will then be responsible for 0% of the Eligible Charge.

Benefits for Outpatient Surgery are subject to a Copayment of $150 per visit. After the Copayment, you will then be responsible for 0% of the Eligible Charge.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient in a Hospital, Skilled Nursing Facility or other eligible facility or a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program at the time that your coverage under this Certificate is terminated, the benefits of this benefit section will be provided until you are discharged from the Hospital or other Provider or until your Hospital days are exhausted, whichever occurs first.

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SUPPLEMENTAL BENEFITS

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

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

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

1. Blood and Blood Components

2. Medical and Surgical Dressings, Supplies, Casts and Splints — Benefits will be provided for medical and surgical dressings, supplies, casts and splints.

3. Oxygen and its administration — Benefits will be provided for oxygen and its administration.

4. Naprapathy Service — Benefits will be provided for Naprapathy Services when rendered by a Naprapath.

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

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

   Examples of Durable Medical Equipment are wheelchairs, Hospital beds, glucose monitors, lancets and lancing devices, ventilators and compression sleeves to prevent or mitigate lymphedema. Benefits will not be provided for strollers, electric scooters, back-up or duplicate equipment, ramps or other environmental devices, or clothing or special shoes. Benefits will be provided for the purchase of cardiopulmonary monitors or durable medical equipment required for temporary therapeutic use. This is only covered when such equipment is primarily and customarily used to serve a medical purpose.

YOUR COST FOR COVERED SERVICES

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

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EMERGENCY CARE BENEFITS

This section of your Certificate explains your emergency care benefits.

Notwithstanding anything in your Certificate to the contrary, for emergency care benefits rendered by Providers who are not part of your HMO's network or otherwise contracted with your HMO, you will not be responsible for any charges that exceed the amount negotiated with Providers for emergency care benefits furnished. Additionally, for emergency treatment and emergency transportation, the out-of-area benefit level will be the same as the in-area benefit level.

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

IN-AREA TREATMENT OF AN EMERGENCY

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

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

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

Payment for In-Area Emergency Treatment

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

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for a Copayment of $200.

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

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

OUT-OF-AREA TREATMENT OF AN EMERGENCY

If you are more than 30 miles away from your Participating IPA/Participating Medical Group and need to obtain treatment for an Emergency Medical Condition, benefits will be provided for the Hospital and Physician services that you receive. Benefits are available for the initial treatment of the emergency and for related follow-up care but only if it is not reasonable for you to obtain the follow-up care from your Primary Care Physician or Woman's Principal Health Care Provider.

Payment for Out-of-Area Emergency Treatment

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

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for a Copayment of $200.

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

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

EMERGENCY AMBULANCE BENEFITS

Benefits for emergency ambulance transportation are available when:

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

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

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SUBSTANCE USE DISORDER TREATMENT BENEFITS

Your coverage includes benefits for the treatment of Substance Use Disorder.

Covered Services are the same as those provided for any other condition, as specified in the other benefit sections of this Certificate. In addition, benefits are available for Covered Services provided by a Substance Use Disorder Treatment Facility or a Residential Treatment Center in the HMO Illinois Network.

INPATIENT BENEFITS

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

BENEFIT PAYMENT FOR INPATIENT BENEFITS

Each time you are admitted as an Inpatient to a Hospital, Substance Use Disorder Treatment Facility or Residential Treatment Center, you are responsible for paying a Copayment of $250 per Inpatient admission. After the Copayment, you will then be responsible for 0% of the Eligible Charge.

COST TO YOU FOR OUTPATIENT BENEFITS

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

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

Detoxification

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

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AWAY FROM HOME CARE® BENEFITS

The Plan is a participant in a nation-wide network of Blue Cross and Blue Shield-affiliated plans. This enables the Plan to provide you with Guest Membership benefits when you are outside the service-area of the Plan.

GUEST MEMBERSHIP

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

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

This would apply for members who are:

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

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

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

You may contact your Employer or Group Administrator to initiate the establishment of a Guest Membership, or you may call Customer Service directly at 1-800-892-2803.

Benefits for Guest Membership

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

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HUMAN ORGAN TRANSPLANT BENEFITS

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

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

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

1. If both the donor and recipient have coverage with the Plan, each will have their benefits paid by their own program.

2. If you are the recipient and your donor does not have coverage from any other source, the benefits of this Certificate will be provided for both you and your donor. The benefits provided for your donor will be charged against your coverage under this Certificate.

3. If you are the donor and coverage is not available to you from any other source, the benefits of this Certificate will be provided for you. However, benefits will not be provided for the recipient.

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

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

1. Organ transplants, services or supplies, and/or Drugs rendered in connection with an organ transplant, which are Experimental/Investigational as determined by the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal department of Health and Human Services that such procedure, service or supply, and/or Drug is either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.

2. Storage fees.

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

4. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.

5. Travel time or related expenses incurred by a Provider.

6. Meals.

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HOSPICE CARE BENEFITS

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

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

The following services are covered under the Hospice Care Program:

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

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

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

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

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

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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.

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OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

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

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

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

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

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

Brand Name Drug means a drug or product that is 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 Brand Name (Preferred or Non-Preferred) 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 Brand Name (Preferred or Non-Preferred).

Brand Name Drug (Non-Preferred) means a Brand Name Drug that is identified on the Drug List as a Brand Name Drug (Non-Preferred). The Drug List is accessible by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

Brand Name Drug (Preferred) means a Brand Name Drug that is identified on the Drug List as a Brand Name Drug (Preferred). The Drug List is accessible by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

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

Compound Drugs 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 or Coinsurance Amount paid by you for each Prescription filled or refilled through a Participating Pharmacy or non-Participating Pharmacy.

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

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 is provided by a Health Care Practitioner;

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3. For which a separate charge is customarily made;

4. Which is not consumed or administered at the time and place that the Prescription 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 drugs that may be covered under this OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS and related services section of this Certificate. A current list is available on our website at https://www.bcbsil.com. 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 the Plan or the entity chosen by the Plan to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with the Plan or the entity chosen by the Plan to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

1. the charge which the particular Pharmacy usually charges for Covered Services, or

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

Generic Drug means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding payment level, the Plan utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information. You should know that not all drugs identified as a “generic” by the drug product database, manufacturer, Pharmacy or your Physician will adjudicate as generic.

Generic Drugs are listed on the Drug List which is available on the Plan's website at www.bcbsil.com. You may also contact customer service at the toll-free number indicated on the back of your identification card.

Generic Drug (**Non-Preferred)** means a Generic Drug that is identified on the Drug List as a Generic Drug (Non-Preferred). The Drug List is accessible by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

Generic Drug (**Preferred)** means a Generic Drug that is identified on the Drug List as a Generic Drug (Preferred). The Drug List is accessible by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

Health Care Practitioner means an Advanced Practice Nurse, doctor of medicine, doctor of dentistry, Physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

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

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

National Drug Code (NDC) means a national classification system for the identification of drugs.

Non-Participating Pharmacy or Non-Participating Prescription Drug Provider means an independent retail Pharmacy, chain of retail Pharmacies, mail order Pharmacy or specialty drug Pharmacy which has not entered into a written agreement

with the Plan to provide pharmaceutical services to you or an entity which has not been chosen by the Plan to administer its prescription drug program services to you at the time you receive the services.

Participating Pharmacy or **Participating Prescription Drug Provider** means an independent retail Pharmacy, chain of retail Pharmacies, mail order Pharmacy or specialty drug Pharmacy which has entered into a written agreement with the Plan to provide pharmaceutical services to you or an entity chosen by the Plan to administer its prescription drug program services to you at the time you receive the services.

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

Preferred Participating Pharmacy means a Participating Pharmacy which has a written agreement with the Plan to provide pharmaceutical services to you or an entity chosen by the Plan to administer its prescription drug program that has been designated as a Preferred Participating Pharmacy.

Preferred Pharmacy means a Participating Pharmacy which has a written agreement with the Plan to provide pharmaceutical services to you or an entity chosen by the Plan to administer its prescription drug program that has been designated as a preferred pharmacy.

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

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

Specialty Drug (Non-Preferred) means a Specialty Drug that is identified on the Drug List as a Specialty Drug (Non-Preferred). The Drug List is accessible by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

Specialty Drug (Preferred) means a Specialty Drug that is identified on the Drug List as a Specialty Drug (Preferred). The Drug List is accessible by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

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

ABOUT YOUR BENEFITS

Drug List

Drugs listed on the Drug List are selected by the Plan based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Plan. 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., 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, drugs moving to a higher payment tier, or drugs requiring therapy or prior authorization) occur only annually. However, when there has been a pharmaceutical manufacturer recall or other safety concern, changes to the Drug List may occur more frequently.

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You, your prescribing Health Care Provider, or your authorized representative, can ask for an exception if your drug is not on (or is being removed from) the Drug List if the drug requires prior authorization before it may be covered, or the dispensing limit has been found to be (or likely to be) not right for you or does not work as well in treating your condition. To request this exception, you, your prescribing Provider, or your authorized representative, can call the number on the back of your identification card to ask for a review. The Plan will let you, your prescribing Provider (or authorized representative) know the coverage decision within 72 hours after they receive your request. If the coverage request is denied, the Plan will let you and your prescribing Provider (or authorized representative) know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals and external exception review process described in the denial determination and outlined in the HOW TO FILE A CLAIM section which described the Independent External Review option.

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 noncovered drug, you, your prescribing Provider, may be able to ask for an expedited review process by marking the review as an urgent request. The Plan will let you, your prescribing Provider (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, the Plan will let you and your prescribing Provider (or authorized representative) know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals and external exception review process described in the denial determination and outlined in the HOW TO FILE A CLAIM section which describes the Independent External Review option. Call the number on the back of your identification card if you have any questions.

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

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

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.

PRIOR AUTHORIZATION REQUIREMENT

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

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

Dispensing Limits

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

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

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

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

Day Supply

In order to be eligible for coverage under this Certificate, the prescribed day supply must be medically necessary and must not exceed the maximum day supply limitation described in this Certificate. The Plan has the right to determine the day supply. Payment for benefits covered under this benefit section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Some drugs covered under your plan may be subject to certain supply/fill limitations pursuant to diagnoses or new-to-therapy requirements, plan design, and/or state or federal regulations. For specific drug supply/fill information, please call the customer service toll-free number located on your identification card. Specialty Drugs are limited to a 30-day supply. However, some Specialty Drugs have FDA Approved dosing regimens exceeding the 30-day supply limited and may be allowed greater than a 30 day-supply, if allowed by your plan benefits. For information on these drugs call the customer service toll-free number located on your identification card. However, early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the prescribing Physician or Optometrist. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained. 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.

Controlled Substances Limitation

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

Prescription Refills

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

1. The prescription drugs are covered under this Certificate 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;

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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.

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

COVERED SERVICES

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

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

2. Has been approved by the FDA for at least one indication and

3. Is recognized by substantially accepted peer- reviewed medical literature for treatment of the indication for which the drug is prescribed to treat you for a chronic, disabling or life-threatening illness.

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

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

A separate Copayment Amount 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.

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.

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.

Cancer Medications

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 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. Coverage of prescribed orally administered cancer medications will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

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Contraceptive Drugs

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

Your share of the cost for all other contraceptive drugs and products will be as shown in the BENEFIT HIGHLIGHTS section of this Certificate.

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. Lancets and lancet devices;
3. Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein;
4. Insulin and insulin analog preparations;
5. Injection aids, including devices used to assist with insulin injection and needleless systems;
6. Insulin syringes;
7. Biohazard disposable containers;
8. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels;
9. Glucagon emergency kits;

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

Hormonal Therapy for Gender Dysphoria

Benefits will be provided at no charge for FDA-approved hormonal therapy medication for the treatment of gender dysphoria, including FDA-approved drugs prescribed for off-label use, when obtained from a Participating Pharmacy, and for follow-up services, when obtained from a Participating Provider.

HIV Post-Exposure Prophylaxis

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

Injectable Drugs

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

Immunosuppressant Drugs

Benefits are available for immunosuppressant drugs with a written prescription afteran approved Human Organ Transplant. If you Physician indicates “may not substitute” on a covered prescribed immunosuppressant drug, BCBSIL will not require a pharmacist to interchange another immunosuppressant drug.

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Fertility Drugs

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

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 your Primary Care Physician or Woman's Principal Health Care Provider after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.

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

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.

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.

Opioid Medically Assisted Treatment

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

Pregnancy Tests

Benefits will be provided for up to two (2) pregnancy tests every thirty (30) days, when prescribed for at-home use.

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, after your program deductible has been met.

Self-Administered Cancer Medications

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

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.

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.

Vaccinations obtained through Participating Pharmacies

Benefits for select vaccinations, including the administration fee, are available through certain Participating Pharmacies that have contracted with the Plan to provide this service. To locate one of these contracting Participating Pharmacies in your area, call the Customer Service toll-free number on your identification card. At the time you receive services, present your

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identification card to the pharmacist. This will identify you as a participant in the Plan's health care plan provided by your employer. The pharmacist will inform you of the amount for which you are responsible for, if any.

Each Participating Pharmacy that has contracted with the Plan 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 Plan's medical coverage for benefits available for childhood immunizations.

90-Day Supply Prescription Drug Program

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

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

If you send an incorrect payment amount for the Covered Drug dispensed, you will:

(a). receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

Member Pays the Difference

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 Amount 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. In order for this request to be reviewed, Your Provider must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. Your Physician must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment Amount and/or Coinsurance Amounts will still apply. For additional information, contact the customer service number on the back of your identification card or visit www.bcbsil.com.

MedsYourWay ™

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

The amount you pay for your Prescription will be applied, if applicable, to your Deductible and out-of-pocket maximum. Available select Covered Drugs and drug discount card pricing through MedsYourWay may change occasionally 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

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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 FOR PRESCRIPTION DRUGS

How Your Cost is Determined

The amount that you are responsible for is based upon the drug tier as described below and shown in the BENEFIT HIGHLIGHTS section of this Certificate.

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

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

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. In order for this request to be reviewed, your Provider must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. Your Physician must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence failure, product quality problems, and product problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment Amount and/or Coinsurance Amounts will still apply. For additional information, contact the customer service number on the back of your identification card or visit www.bcbsil.com.

To obtain additional information about your benefits for a drug, visit the Plan's website at www.bcbsil.com and log into Blue Access for Members or call the number on the back of your identification card. Benefits will be provided as shown in the BENEFIT HIGHLIGHTS section of this Certificate.

34-Day Supply Prescription Drug Program

Benefit payment for the 34-day supply prescription drug program

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

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 Participating Pharmacy.

When you purchase drugs (other than Specialty Drugs) from a Participating Prescription Drug Provider, you will not be charged any amount other than the specified Copayment Amount. The Copayment Amounts are shown in the BENEFIT HIGHLIGHTS section of this Certificate. You will be charged the Copayment Amount for each prescription.

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One prescription means up to a 34 consecutive day supply for most medications. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs, larger quantities may be obtained through the 90-day supply prescription drug program. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives. For additional information on these drugs, contact the customer service toll-free number on your identification card.

Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty 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 the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.)

No benefits will be provided when you purchase drugs or diabetic supplies from a Non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider). However, if the Non-Participating Prescription Drug Provider is located outside of a Participating Pharmacy network, then benefits for drugs or diabetic supplies purchased for Emergency Medical Conditions will be provided and you will be responsible for the specified Copayment Amount shown in the BENEFIT HIGHLIGHTS section of this Certificate. You will be charged the Copayment Amount for each prescription.

90-Day Supply Prescription Drug Program

Benefit payment for the 90-day supply prescription drug program

In addition to the benefits described in this benefit section, your coverage includes benefits for maintenance type drugs and diabetic supplies purchased from a Participating Prescription Drug Provider (which may include retail or mail order pharmacies) participating in the 90-day supply prescription drug program. You will not be charged any amount other than the Copayment amount specified in the section of this Certificate. You may also receive coverage for up to a 12-month supply for dispensed contraceptives.

When you purchase Specialty Drugs from a Participating Prescription Drug Provider participating in the 90-day supply drug program, you will not be charged any amount other than the Coinsurance Amount specified in the BENEFIT HIGHLIGHTS section of this Certificate. You will be charged the Coinsurance Amount for each prescription.

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

Should you choose to obtain a 90-day supply Prescription Drug Order from a mail order Pharmacy, you can obtain an order form from your Group or from the Plan.

Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty 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 the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed).

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

EXCLUSIONS

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

1. Drugs/products which are not included on the Drug List, unless specifically covered elsewhere in this Certificate and/or such coverage is required in accordance with applicable law or regulatory guideline.

2. Non-FDA approved Drugs.

3. Drugs which do not by law require a Prescription from a Provider or Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs or covered devices for which no valid Prescription is obtained.

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4. Devices, Technologies and or durable medical equipment of any type (even though such devices may require a Prescription) such as, but not limited to, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self- administered injections and those devices listed as diabetes supplies).

5. Pharmaceutical aids, such as, excipients found in the USP-NF (United States Pharmacopeia- National Formulary), including but not limited to, preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.

6. Administration or injection of any drugs.

7. Vitamins (except prenatal vitamins, when prescribed by a Physician or Advanced Practice Nurse, and those vitamins which by law require a Prescription and for which there is no non-prescription alternative).

8. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

9. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper Claim be, provided under the Workers' Compensation law.

10. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.

11. Drugs which are repackaged by a company other than the original manufacturer.

12. Drugs required by law to be labeled: “Caution — Limited by Federal Law to Investigational Use,” or experimental drugs, even though a charge is made for the drugs, or are Experimental/Investigational, except as specifically mentioned in this Certificate.

13. 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.

14. 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 Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

15. Drugs, that the use or intended use of which would be illegal, abusive, not medically necessary, or otherwise improper.

16. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.

17. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted.

18. Rogaine, Minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

19. Compounded drugs that do not meet the definition of Compound Drugs in this portion of your benefit section or that are determined to be high-risk compounds.

20. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of wrinkles and skin aging.

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21. Prescriptions for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined.

22. Athletic performance enhancement drugs.

23. Allergy serum and allergy testing materials.

24. Injectable drugs, except those determined by the Plan to be self-administered.

25. Some drugs have therapeutic/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered your Benefit Section, the drug purchased will not be covered under any benefit level.

26. Certain drug classes where there are over-the-counter alternatives available.

27. All Brand Name Drugs in a drug class where there is an over the counter alternative available.

28. Drugs prescribed for the treatment of heartburn, gastroesophageal reflux disease (GERD), or acid reflux.

29. Brand-name Proton Pump Inhibitors.

30. Compound Drugs

31. Medications in depot or long acting formulations that are intended for use longer than the covered days' supply amount.

32. Drugs determined to have inferior efficacy or significant safety issues.

33. Devices and pharmaceutical aids.

34. Repackaged medications and institutional packs and drugs which are repack aged by anyone other than the other manufacturer.

35. Institutional packs and drugs which are repackaged by anyone other than the original manufacturer.

36. Surgical supplies.

37. Ostomy products.

38. Diagnostic agents, (except for diabetic testing supplies or test strips).

39. General anesthetics.

40. Bulk powders.

41. New-to-Market FDA-approved medications which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

42. Drugs that are not considered medically necessary or treatment recommendation that are not supported by evidence-based guidelines or clinical practice guidelines.

43. 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).

44. 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.

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HEARING AID BENEFITS

Your Hearing Aid benefit period begins on the date you first receive a Hearing Aid after the date that your coverage began and continues through the benefit period. Later benefit periods will begin on the first day that you receive a Hearing Aid after expiration of your prior established Hearing Aid benefit period.

Hearing Aids

This plan provides benefits for medically necessary Hearing Aids when a Hearing Care Professional prescribes a Hearing Aid to augment communication as follows:

1. One Hearing Aid will be covered for each ear every 24 months;
2. Related services, such as audiological examinations and selection, fitting, and adjustment or ear molds to maintain optimal fit will be covered when deemed medically necessary by a Hearing Care Professional; and
3. Hearing Aid repairs will be covered when deemed medically necessary.

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PRE-ADMISSION CERTIFICATION AND CONCURRENT REVIEW

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

PRE-ADMISSION CERTIFICATION

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

Note: You may be responsible for a penalty, not to exceed $1000.00, in the event you or your health care provider fail to obtain pre-admission certification.

CONCURRENT REVIEW

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

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

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EXCLUSIONS—WHAT IS NOT COVERED

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

1. Services or supplies that are not specifically stated in this Certificate.

2. Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the EMERGENCY CARE BENEFITS section, PHYSICIAN BENEFITS section and HOSPITAL BENEFITS section of this Certificate.

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

4. Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated.

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

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

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

8. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental/Investigational in nature. This exclusion however does not apply to a) the cost of routine patient care associated with Investigational treatment if you are a qualified individual participating in an Approved Clinical Trial program, if those services or supplies would otherwise be covered under this Certificate if not provided in connection with an Approved Clinical 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.

9. 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.

10. Custodial Care Service.

11. Long Term Care Services.

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

13. 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.

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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).

14. Special education therapy such as music therapy or recreational therapy, except as specifically provided for in this Certificate.

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

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

17. 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.

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

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

20. Special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants except as specifically stated in this Certificate.

21. 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.

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

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

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

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

26. Inpatient Private Duty Nursing Service.

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

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28. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate.

29. 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.

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

31. Maintenance Care.

32. Self-management training, education and medical nutrition therapy, except as specifically stated in this Certificate.

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

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

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

36. Services or supplies rendered for human organ or tissue transplants except as specifically provided for in this Certificate.

37. Elective sterilization, except as otherwise provided in the Certificate.

38. Sterilization, except as otherwise provided in the Certificate.

39. The reversals of sterilization.

40. Services or supplies rendered for Infertility treatment except as specifically provided for in this Certificate.

41. Eyeglasses or contact lenses except as specifically provided for in this Certificate.

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

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

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

45. Viscosupplementation (intra-articular hyaluronic acid injection) except for individuals currently receiving maintenance therapy.

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COORDINATION OF BENEFITS

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

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

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but

2. May be reduced when, under the order of benefits determination rules, another Benefit Program determines its benefits first. This reduction is described below in "When this Benefit Program is a Secondary Program."

In addition to the DEFINITIONS section of this Certificate, the following definitions apply to this section:

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

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

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

Benefit Program means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

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

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

Primary Program or Secondary Program means the order of payment responsibility as determined by the order of benefit determination rules.

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

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

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

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ORDER OF BENEFIT DETERMINATION

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

1. The other Benefit Program has rules coordinating its benefits with those of this Benefit Program; and

2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's benefits be determined before those of the other Benefit Program.

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

1. Non-Dependent or Dependent

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

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

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

2. Dependent Child if Parents not Separated or Divorced

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

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

   b. If both parents have the same birthday, the benefits of the Benefit Program that covered the parents longer are determined before those of the Benefit Program that covered the other parent for a shorter period of time. However, if the other Benefit Program does not have this birthday- type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of benefits, the rule in the other Benefit Program will determine the order of benefits.

3. Dependent Child if Parents Separated or Divorced

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

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

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

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

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

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4. Dependent Child if Parents Share Joint Custody

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

5. Young Adults as a Dependent

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

7. Continuation Coverage

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

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

   b. Second, the benefits under the continuation coverage.

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

8. Length of Coverage

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

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

1. The benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and

2. The benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a Claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Benefit Program will be reduced so that they and the benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

The foregoing not withstanding, you will only be responsible for any applicable Copayments, deductibles and/or Coinsurance as described in this Certificate.

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

ADDITIONAL BENEFITS — SAVINGS

The amount by which your benefits under this Benefit Program have been reduced is called your “savings.” Savings can be used to pay for services that are not covered under this Benefit Program provided that the services are covered under another Benefit Program and were not completely paid for under that Benefit Program. Savings can only be used to pay for services rendered in the same calendar year in which the Claim that earned the savings is actually processed.

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

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HOW TO FILE A CLAIM

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

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

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

1. an itemized bill from the Hospital, Physician or other Provider (including the Provider's name and address, the patient's name, the diagnosis, the date of service, a description of the service and the Claim Charge);

2. the Eligible Person's name and Plan identification number;

3. the patient's name, age and sex; and

4. any additional relevant information.

Mail all of that information to:

Blue Cross and Blue Shield

300 East Randolph Street

Chicago, Illinois 60601-5009

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

If you have any questions about a Claim, call **customer service at 1-800-892-2803**

FILING OUTPATIENT PRESCRIPTION DRUG PROGRAM CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits under the Outpatient Prescription Drug Program. 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 or non-Preferred Prescription Drug Provider. To do so, follow these instructions:

1. Complete an Outpatient Prescription Drug Program Claim Form. These forms are available from your Employee Benefits Department or from the Plan.

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:

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Prime Therapeutics

P. O. Box 25136

Lehigh Valley, PA 18002-5136

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received, will not be eligible for payment.

Should you have any questions about filing Claims, please call the Plan.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS INITIAL CLAIMS DETERMINATIONS

The Plan 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 the Plan 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. The Plan 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” provisions in the OTHER THINGS YOU SHOULD KNOW section of this Certificate.)

If a Claim Is Denied or Not Paid in Full

If the Claim for benefit is denied in whole or in part, 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 the Claim 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 the Plan'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 would like to add);

    b. An explanation that you may ask for an external review with an Independent Review Organization (“IRO”) not associated with the Plan if your appeal was denied based on any of the reasons below. You may also ask for external review if the Plan failed to give you a timely decision (see iv. 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) or your health care coverage was rescinded.

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c. To ask for an external review, complete the Request for External Review form that will be provided to you as part of this notice and available at insurance.illinois.gov/external review and submit it to the Department of Insurance at the address shown below for external reviews;

d. 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) The Plan 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.

e. 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 you received Emergency Services, but have not been discharged from a facility;

f. Decisions on standard appeals are considered timely if the Plan sends you a written decision for appeals that need medical review within 15 business days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. Decisions on expedited appeals are considered timely if the Plan sends you a written decision within 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 the Plan;

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 consumer assistance and ombudsman:

For Complaints and general Inquiries:

Springfield Office
Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767
866-445-5364: toll free
866-323-5321: TDD
217-782-4515: phone
217-782-5020: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

Chicago Office
115 S. LaSalle Street, 13th floor
Chicago, IL 60603
312-814-2420: phone
312-814-5416: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington Street
Springfield, Illinois 62767
(877) 850-4740 Toll-free phone
(217) 557-8495) Fax number
DOI.ExternalReview@illinois.gov
https://mc.insurance.illinois.gov/messagecenter

INQUIRIES AND COMPLAINTS

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

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

The Plan 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 contact **Customer Service** at the number on the back of your identification card, or you may write to:

Blue Cross and Blue Shield

300 East Randolph Street

Chicago, Illinois 60601-5009

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

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

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

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Plan must notify you within:	24 hours**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Plan within:	48 hours after receiving notice
The Plan 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

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After receiving the completed Claim (if the initial Claim is incomplete), within:	48 hours

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

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

Pre-Service Claims

Type of Notice or Extension	**Timing**
If your Claim is filed improperly, the Plan must notify you within:	5 days*
If your Claim is incomplete, the Plan must notify you within:	15 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Plan within:	45 days after receiving notice
The Plan must notify you of the Claim determination (whether adverseor not):	
If the initial Claim is complete, within:	15 days**
After receiving the completed Claim (if the initial Claim is incomplete), within:	30 days
If you require post-stabilization care after an emergency within:	The time appropriate to the circumstance not to exceed one hour after the time of request

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

** This period may be extended one time by the Plan for up to 15 days,provided that the Plan 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 the Plan expects to render a decision.

Post-Service Claims

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

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After receiving the completed Claim (if the initial Claim is incomplete), within:	45 days

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

Concurrent Care

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

CLAIM APPEAL PROCEDURES

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

1. In addition, an Adverse Benefit Determination, also includes an "Adverse Determination." An **"Adverse Determination"** means: determination by the Plan or its designated utilization review organization that, based upon the information provided, a request for a benefit under the Plan's health benefit plan upon application of any utilization review technique does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or it 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 determination.

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, the Plan will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Plan 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 the Plan.

How to Appeal an Adverse Benefit Determination

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

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An appeal of an Adverse Benefit Determination may be filed by you or a personauthorized to act on your behalf. In some circumstances, a health care Providermay appeal on their own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Plan at the number on the back of your identification card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

If you believe the Plan incorrectly denied all or part of your benefits, you may have your Claim reviewed. The Plan 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 the Plan to request a Claim review. The Plan 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 the Plan. 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 the Plan to request a Claim review or appeal an Adverse Benefit Determination, use the following contact information:

Claim Review Section

Blue Cross and Blue Shield of Illinois

P.O. Box 660603 Dallas, TX 75266-0603

1-800-538-8833 Toll-free number

1-866-414-4258 Fax number

Fax number 1-918-551-2011 Fax number for Urgent requests

send a secure email by using our message center logging into Blue Access for Members®(“BAM”)

at www.bcbsil.com

During the course of your internal appeal(s), the Plan will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by the Plan 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 will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. The Plan may extend the time period described in this Certificate for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Plan 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 the Plan.

Timing of Non-Urgent Appeal Determinations

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

The Plan will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 15 business days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 15 business days after receipt

of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you have 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

The Plan 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 to you or your authorized representative will include:

1. The reasons for the determination;

2. A reference to the benefit plan provisions on which the determination is based, and 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 the Plan's internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal and 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 would like to add);

    b. An explanation that you may ask for an external review with an Independent Review Organization (“IRO”) not associated with the Plan if your appeal was denied based on any of the reasons below. You may also ask for external review if the Plan failed to give you a timely decision (see iii. 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 (see your Certificate for details); To ask for an external review, complete the Request for External Review form that will be provided to you as part of this notice and available at insurance.illinois.gov/externalreview and submit it to the Department of Insurance at the address shown below for external reviews.

5. An explanation that you may ask for an expedited (urgent) external review if:

    a. 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;

    b. The Plan failed to give you a decision within 48 hours of your request for an expedited appeal;

    c. 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

    d. The 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.

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6. Decisions on standard appeals are considered timely if the Plan sends you a written decision for appeals that need medical review within 15 business days after we receive any needed information, but not 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 the Plan sends you a written decision within 48 hours of your request for an expedited appeal.

7. 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;

8. 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);

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

10. 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;

11. 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;

12. 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;

13. A description of the standard that was used in denying the Claim and a discussion of the decision;

14. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on their own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;

15. 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;

16. 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;

17. The number of levels of appeal available (no more than two levels for group and one level for individual) under the Plan and the level of appeal applicable to the adverse determination within the notice;

18. 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—

19. Experimental/Investigational Review Form; and

20. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For Complaints and General Inquiries:

Springfield Office
Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767
866-445-5364: toll free
866-323-5321: TDD
217-782-4515: phone
217-782-5020: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

Chicago Office
115 S. LaSalle Street, 13th floor
Chicago, IL 60603
312-814-2420: phone
312-814-5416: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

For external review requests:

Illinois Department of Insurance

Office of Consumer Health Insurance

EXTERNAL REVIEW REQUEST

115 S. LaSalle Street, 13th Floor

Chicago, IL 60603

(877) 850-4740 Toll-free phone

(217) 557-8495) Fax number

DOI.ExternalReview@illinois.gov

https://mc.insurance.illinois.gov/messagecenter

If the Plan'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 section below.

You may file a complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Plan of the Complaint. The Plan will have 21 days to respond to the Illinois Department of Insurance.

The operations of the Plan 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.

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For Complaints, the Illinois Department of Insurance can be contacted at:

Springfield Office
Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767
866-445-5364: toll free
866-323-5321: TDD
217-782-4515: phone
217-782-5020: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

Chicago Office
115 S. LaSalle Street, 13th floor
Chicago, IL 60603
312-814-2420: phone
312-814-5416: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

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

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

If You Need Assistance

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

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

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 1-877-527-9432, 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 review 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 the Plan or its designated utilization review organization, at the completion of the Plan's internal grievance process procedures.

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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 4 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 REQUEST
320 W. Washington Street
Springfield, IL 62767
Other appropriate Address
Phone Number (877) 850-4740
Fax (217) 557-8495
DOI. externaleview@illinois.gov
http://insurance.illinois.gov/ExternalReview/ExternalReviewMain.html

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 the Plan.

a. **Preliminary Review**

Within five business days of receipt of the request from the Director, the Plan will complete a preliminary review of your request to determine whether:

- You were an Enrollee at the time health care service was requested or provided;
- The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this benefit program, but the Plan has determined that the health care service is not covered;
- You have exhausted the Plan's internal appeal process, unless you are not required to exhaust the Plan's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and
- 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, the Plan 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 the Plan'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:

- Standard health care services or treatments have not been effective in improving your condition;
- Standard health care services or treatments are not medically appropriate for you; or
- There is no available standard health care services or treatment covered by the Plan that is more beneficial than the recommended or requested service or treatment;
- 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 a 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.

b. **Notification.** Within one business day after completion of the preliminary review, the Plan shall notify the Director, you and your authorized representative, if applicable, in writing whether the request is complete and eligible for an external

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review. If the request is not complete or not eligible for an external review, the Director, you and your authorized representative shall be notified by the Plan in writing of what materials are required to make the request complete or the reason for its ineligibility. The Plan's determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director. The Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director'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.

c. **Assignment of IRO.** When the Director receives notice that your request is eligible for external review following the preliminary review, the Director 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 Director; and (b) notify the Plan, 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 Director of assignment of an IRO, the Plan shall 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 the Plan 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 the Plan 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 the Plan, 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 the Plan within one business day of receipt from you or your authorized representative. Upon receipt of such information, the Plan may reconsider the Adverse Determination or Final Adverse Determination. Such reconsideration shall not delay the external review. The Plan 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 Plan shall notify the Director, the IRO, you, and if applicable, your authorized representative of its decision to reverse the determination.

d. **IRO's Decision.** In addition to the documents and information provided by the Plan and you, or if applicable, your authorized representative, the IRO shall also consider the following information if available and appropriate:

   - Your pertinent medical records;
   - Your health care Provider's recommendation;
   - Consulting reports from appropriate health care Providers and other documents submitted to the Plan or its designated utilization review organization, you, your authorized representative or your treating provider;
   - The terms of coverage under the benefit program;
   - 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;
   - Any applicable clinical review criteria developed and used by the Plan or its designated utilization review organization; and
   - 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 the Plan will choose or control the choice of the Physicians or other health care professionals 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 Director, the Plan, you and your authorized representative, if applicable, of its decision.

The written notice will include:

1. A general description of the reason for the request for external review;
2. The date the IRO received the assignment from the Director;
3. The time period during which the external review was conducted;
4. 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 reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
5. The date of its decisions;
6. The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and
7. The rationale for its decision.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program even if the IRO determines that the health care services being reviewed were medically appropriate.

The IRO is not bound by any Claim determinations reached prior to the submission of information to the IRO. The Director, you, your authorized representative, if applicable, and the Plan will receive written notice from the IRO.

Standard External Review

Standard External Review	Timing
If you receive an Adverse Determination or a Final Adverse Determination, you may file a request for an external review within:	4 months after receipt of notice
The Plan shall complete a preliminary review of the request within:	5 business days after receiving request
The Plan must notify you whether the request is complete and eligible for external review:	

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If the request is not complete the Plan shall notify you and include what information or materials are required within:	one businessday after the preliminary review
if the request is not eligible for external review the Plan shall notify you and include the reasons for its ineligibility within:	one business day after the preliminary review
The Plan shall notify you that a request is eligible for external review within:	one businessday after the preliminary review
The Director shall assign an independent review organization (IRO) within:	5 business days
The Plan shall provide to the assigned IRO the documents and any information used in making the Adverse Determination or Final Adverse Determination within:	5 business days of notice of assigned IRO
The IRO shall provide notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination within:	5 days after receipt of all required information from you (but no more than 45 days after the receipt of request for external review)

2. 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 the Plan. 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 of if the Plan 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 Director either orally (by calling 1-877-850-4740) or in writing as set forth above for requests for standard external review.

Notification. Upon receipt of a request for an expedited external review, the Director shall immediately send a copy of the request to the Plan. The Plan shall immediately notify the Director, you and your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review. The Plan's determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director. The Director 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, the Director'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.

Assignment of IRO. If your request is eligible for expedited external review, the Director shall immediately assign an IRO on a random basis from the list of IROs approved by the Director; and immediately notify the Plan of the name of the IRO.

Upon receipt from the Director of the name of the IRO assigned to conduct the external review, the Plan 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. If the Plan 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 Director, the Plan, 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 Director, the Plan, 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 Director, the Plan 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 your 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 Director, the Plan, 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 Director, the Plan and, if applicable, your authorized representative.

The assigned IRO is not bound by any decisions or conclusions reached during the Plan's utilization review process or the Plan's internal appeal process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program if the IRO determines that the health care services being appealed were medically appropriate.

An external review decision is binding on the Plan. 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.

Expedited External Review	Timing
You may file a request for an expedited external review after the date of receipt of a notice prior to Final Adverse Determination:	immediately
You may file a request for an expedited external review if the Plan fails to provide a decision on a request for an expedited internal appeal within:	48 hours

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The Plan must immediately notify you whether the request is complete and eligible for anexpedited external review or is ineligible for review and may be appealed to the Director. The Director may make a determination that the request is eligible for an expedited external review,notwithstanding the Plan's determination.	
The Director shall assign an independent review (IRO): organization (IRO)	immediately
The Plan shall provide all necessary documents and information to the IRO:	immediately, but not more than 24 hours after assignment of an IRO
Expedited External Review	Timing
If the Plan fails to provide the necessary documents and information within the required time mentioned above, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination.	
The IRO shall provide notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination to the Plan, the Director and you:	as expeditiously as your medical condition or circumstances require,but no more than 72 hours after thereceipt of request.
Experimental or Investigational Treatment External Review	Timing
You may file a request with the Director for an external review after receipt of an AdverseDetermination or a Final Adverse Determination within:	4 months after date of receipt
If your treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may make an oral request for an expedited external review, after which the Director shall immediately notify the Plan and the time frames otherwise applicable to Expedited External Review shall apply.	
After the receipt for an external review, the Director shall send a copy of the request to the Plan within:	one business day
The Plan shall complete a preliminary review of the request within:	5 business days
After completion of the preliminary review, the Plan shall notify you and the Director whether the request is complete and eligible for external review within.	one business day
When the Director receives notice that the request is eligible for external review, the Director shall:	
assign an IRO and notify the Plan of the name of the IRO, within:	one business day
notify you of the request's eligibility and acceptance for external review and the name of the IRO, within:	one business day

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If you are notified that your request for an external review has been accepted, you must submit additional information to the assigned IRO within:	5 business days
The assigned IRO shall then select one or more clinical reviewers within:	one business day
Experimental or Investigational Treatment External Review	Timing
The Plan shall provide to the assigned IRO the documents and any information used in making the Adverse Determination or Final Adverse Determination within:	5 business days of notice of assigned IRO
After being selected by the assigned IRO, each clinical reviewer shall provide an opinion to the assigned IRO on whether the recommended or request health care service shall be covered within:	20 days
or, in the case of an expedited external review:	immediately, but in no event morethan 5 calendar days
The assigned IRO shall make a decision after receipt of the opinion from each clinical reviewer and provide notification of the decision to the Director, you and the Plan within:	20 days
or, in the case of an expedited external review, within:	48 hours after receipt of the opinionof each clinical reviewer

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OTHER THINGS YOU SHOULD KNOW

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits have been provided for Covered Services described in this Policy, you agree:

1. The Plan has the right to reimbursement for all benefits the Plan 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:

   a. in the case of health care facilities and certain contracted Providers, the calculation of any lien shall be based on the amount the Plan charges the group's experience for Covered Services rendered to you; and

   b. in the case of Providers other than health care facilities, the calculation of any lien shall be based on the Plan's benefit payment for Covered Services rendered to you.

2. The Plan is assigned the right to recover from the third party, or their insurer, to the extent of the benefits the Plan provided for that sickness or injury. The Plan shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses the Plan has provided as a result of that sickness or injury.

   For the purposes of this provision, the cost of benefits provided will be the charges that would have been billed if you had not been enrolled under this benefit program.

   You are required to furnish any information or assistance and to provide any documents that the Plan may request in order to obtain its rights under this provision.

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Plan has contracts with certain Providers and other suppliers of goods and services for the provision of and/or payment for health care goods and services to all persons entitled to health care benefits under individual and group policies or contracts to which the Plan is a party, including all persons covered under your Group's Policy.

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

1. receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which the Plan was obligated to pay the Provider or supplier, or

2. pay Providers or suppliers substantially less than their Claim Charges for goods or services, by discount or otherwise, or

3. receive from Providers or suppliers other substantial allowances under the Plan's contracts with them.

Your Group understands that the Plan may receive such payments, discounts, and/or other allowances during the term of the Policy.

Neither you nor your Group are entitled to receive any portion of any such payments, discounts, and/or other allowances. Any Copayments and/or deductibles payable by you are pre-determined fixed amounts, based upon the selected benefit plan, which are not impacted by any discounts or contractual allowances which the Plan may receive from a Provider.

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INTER-PLAN ARRANGEMENTS

Out-of-Area Services

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

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

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

BlueCard® Program

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

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

Emergency Care Services:

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

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

1. The billed charges for your Covered Services, or

2. The negotiated price that the Host Blue makes available to the Plan.

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

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

Non-Participating Healthcare Providers Outside the Service Area Liability Calculation

1. In General:

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

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

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

2. Exceptions:

   In some exception cases, the Plan may, but is not required to negotiate a payment with such non-participating health care Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:

   a. The amount calculated using the methodology described in the Certificate for non-participating Providers located inside our service area (and described in Section (a) above); or

   b. The following:

      (i) For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or

      (ii) For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

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

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

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global® Core Service Center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost share amounts/deductibles, Coinsurance, etc. In such

cases, the Hospital will submit your Claims to the Blue Cross Blue Shield Global® Core Service Center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services.

Outpatient Services

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

Submitting a 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 and the Provider's itemized bill(s) to the service center (the address is on the form) to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from the Plan, 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.

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Plan's Separate Financial Arrangements with Prescription Drug Providers

The Plan hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers (“Participating Prescription Drug Providers”) to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Plan is a party, including all persons covered under this Certificate. Under its contracts with Participating Prescription Drug Providers, the Plan may receive from these Providers discounts for prescription drugs dispensed to you. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

Coinsurance Amounts payable by you under this Certificate will be calculated on the basis of the Provider's Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider and the Plan for a prescription drug, whichever is lower.

To help you understand how the Plan's separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

1. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is $100. How is the $100 paid?

2. You personally will have to pay the Coinsurance Amount set out in this Certificate.

3. 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.

4. In our example, if your Coinsurance obligation is 25%, you personally will have to pay 25% of $80, or $20. You should note that your 25% Coinsurance is based upon the discounted amount of the prescription and not the full $100 bill.

5. For the 90-day supply prescription drug program and Specialty Pharmacy program partially owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the 90-day supply prescription drug program and/or Specialty Pharmacy program. The Plan pays a fee to Prime for Pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and home delivery processing.

6. “Weighted Paid Claim" refers to the methodology of counting Claims for purposes of determining the Plan's fee payment to Prime. Each retail (including Claims dispensed through PBM's Specialty Pharmacy program) paid Claim will be weighted according to the days' supply dispensed. A paid Claim is weighted in 34 day supply increments so a 1-34 days' supply is considered 1 weighted Claim, a 35-68 days' supply is considered 2 weighted Claims, and the pattern continues up to 6 weighted Claims for 171 or more days' supply. The Plan pays Prime a Program Management Fee (“PMF”) on a per weighted Claim basis.

7. The amounts received by Prime from the Plan, Pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a Claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Plan (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 Certificate. 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 the Plan and other Blue Plan operating divisions.

Plan's Separate Financial Arrangements with Pharmacy Benefit Managers

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

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

All benefit payments may be made by the Plan directly to any Provider furnishing the Covered Services for which such payment is due, and the Plan is authorized by you to make such payments directly to such Providers. However, the Plan reserves the right to pay any benefits that are payable under the terms of this Certificate 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 the Plan's benefit payment. The Plan reserves the right to require submission of a copy of the Assignment of Benefit Payment. You will not receive any notices regarding Covered Services received from your Primary Care Physician (or other Providers who are part of your Participating IPA/Participating Medical Group) because Claims do not have to be filed for those services.

Once Covered Services are rendered by a Provider, you have no right to request that the Plan not pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Plan will have no liability to you or any other person because of its rejection of such request.

Except for the assignment of benefit payment described above, neither this Certificate nor a covered person's Claim for payment of benefits under this Certificate is assignable in whole or in part to any person or entity at any time, and coverage under this Certificate 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.

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. PCP Selection

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

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

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

2. OB/GYN Care

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

3. Continuity of Care

If you are under the care of a Participating Provider as defined in this 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.

4. Federal No Surprises Act Definitions

The definitions below apply only to this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section. To the extent the same terms are also defined in the **DEFINITIONS** section of this 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 individual and their 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 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.

"**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.

"**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.

"**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.

"**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.

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"**Recognized Amount**" means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

5. Federal No Surprises Act Surprise Billing Protections

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating emergency facilities. The items and services included in these protections ("Included Services") are listed below.

a. Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.

b. Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections).

c. Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider. Additionally, under Illinois law, in the event there is a payment dispute between the Non-Participating Provider and BCBSIL and attempt to negotiate a payment resolution are unsuccessful, the Non-Participating Provider or BCBSIL may initiate binding arbitration by filing a request with the Department of Insurance. The requesting party shall notify the non-requesting party that arbitration has been initiated, along with its final offer for settlement. The non-requesting party must also share its final offer with the requesting party before arbitration occurs. In the event there is still no resolution regarding the payment of services, the parties may move forward in the arbitration process with an impartial third-party arbiter pursuant to the provisions in 215 ILCS 5/356z.3a.

Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating emergency facility, the Recognized Amount is used to calculate your cost-share requirements, including deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost-share requirements, including deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward your Participating Provider deductible and/or Out-of-Pocket Limit, if any.

6. Federal No Surprises Act Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or Non-Participating emergency facility, the most the Non-Participating Provider or Non-Participating emergency facility may bill you is your in-network cost-share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your

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protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

COVERED SERVICES EXPENSE LIMITATION

If you have Individual Coverage and during any one calendar year, the total amount of any Copayments, deductibles and/or Coinsurance amounts for Covered Services under this Certificate equals $3,000, then any additional Copayment, deductible and/ or Coinsurance amount that you pay towards Covered Services will be reimbursed by the Plan.

If you have Family Coverage and during any one calendar year, the total amount of any Copayments, deductibles and/or Coinsurance amounts that your family pays towards Covered Services equals $6,000, then any additional Copayment, deductible and/or Coinsurance amount that your family pays towards Covered Services will be reimbursed by the Plan. A family member may not apply more than the individual expense limit as described above towards the family expense limit.

In the event your Physician or the Hospital requires you to pay any additional Copayments, deductible and/or Coinsurance amounts after you have met the above provision, upon receipt of properly authenticated documentation, the Plan will reimburse to you, the amount of those Copayments, deductibles and/or Coinsurance amounts.

Copayments and deductibles required under this Certificate are not to exceed 50% of the usual and customary fee for any single service.

This Covered Services expense limitation does not include:

1. Services, supplies or charges excluded under this Certificate
2. Charges described under the SUPPLEMENTAL BENEFITS section of this Certificate
3. Charges for hearing aids as described under the HEARING AIDS BENEFITS section of this Certificate

YOUR PROVIDER RELATIONSHIPS

The choice of a Hospital, Participating IPA, Participating Medical Group, Primary Care Physician or any other Provider is solely your choice and the Plan will not interfere with your relationship with any Provider.

The Plan does not itself undertake to provide health care services, but solely to arrange for the provision of health care services and to make payments to Providers for the Covered Services received by you. The Plan is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Plan. Any contractual relationship between a Physician and a Hospital or other Provider should not be construed to mean that the Plan is providing professional service.

Each Provider provides Covered Services only to Enrollees and does not interact with or provide any services to any Group (other than as an individual Enrollee) or any Group's ERISA Health Benefit Program.

FAILURE OF YOUR PARTICIPATING IPA OR PARTICIPATING MEDICAL GROUP TO PERFORM UNDER ITS CONTRACT

Should your Participating IPA or Participating Medical Group fail to perform under the terms of its contract with the Plan or fail to renew such contract, the benefits of this Certificate will be provided for you for Covered Services received from other Providers limited to Covered Services received during a thirty day period beginning on the date of the Participating IPA's/Participating Medical Group's failure to perform or failure to renew its contract with the Plan. During this thirty-day period, you will have the choice of transferring your enrollment to another Participating IPA or Participating Medical Group

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or of transferring your coverage to any other health care coverage then being offered by your Group to its members. Your transferred enrollment or coverage will be effective thirty-one days from the date your Participating IPA or Participating Medical Group failed to perform or failed to renew its contract with the Plan.

ENTIRE POLICY

The Group Policy, including the Certificate, any Addenda and/or Riders, the Benefit Program Application of the Group for the Policy and the individual applications, if any, of the Enrollees constitutes the entire contract of coverage between the Group and the Plan.

AGENCY RELATIONSHIPS

Your Group is your agent under this Certificate. Your Group is not the agent of the Plan.

CONTINUITY OF CARE

If you are under the care of a Primary Care Physician or a Woman's Principal Health Care Provider or other Provider who leaves the Plan's network (for reasons other than termination of a contact in situations involving imminent harm to a patient or a final disciplinary action by State licensing board, and your Provider agrees, you may be able to continue receiving Covered Services with that Provider for the following:

1. An Ongoing Course of Treatment for a serious acute disease or condition requiring complex ongoing care that you are currently receiving, such as (for example, you are currently receiving Chemotherapy, radiation therapy, or postoperative visits for a serious acute disease or condition);

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 Provider who is terminating from the network would worsen the condition or interfere with anticipating outcomes.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than (90) days from the date of the notices to the Eligible Person of the Provider's termination from the network plan, or if the Enrollee has entered the second or their 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 HMO Enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy, and your Physician does not belong to the Plan's network, but is within the Plan's service area, you may request the option of transition of care benefits. You must submit a written request to the Plan for transition of care benefits within 15 business days of your eligibility effective care, or if you have entered the second or their trimester of pregnancy at the time of Provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery. The Plan may authorize transition of care benefits for a period up to 90 days from the effective date of enrollment. Authorization of benefits is dependent on the Physician's agreement to contractual requirements and submission of detailed treatment plan. A written notice of contractual requirements and submission of detailed treatment plan. A written notice of the Plan's determination will be sent to you within 15 days of receipt of your request.

You have the right to appeal any decision made for a request for benefits under this provision as explained in the CLAIM APPEAL PROCEDURES provision in the HOW TO FILE A CLAIM section of this Certificate.

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NOTICES

Any information or notice which you furnish to the Plan under this Certificate must be in writing and sent to the Plan at its offices at 300 East Randolph Street, Chicago, Illinois, 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which the Plan furnishes to you must be in writing and sent to you at your address as it appears on the Plan's records or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Plan's records.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate until at least 60 days have elapsed since a Claim has been furnished to the Plan in accordance with the requirements of this Certificate. In addition, no such action may be brought once 3 years have elapsed from the date that a Claim is required to be furnished to the Plan in accordance with the requirements of this Certificate.

VALUE BASED DESIGN PROGRAMS

The Plan has the right to offer medical management programs, quality improvement programs, and health behavior wellness incentives, maintenance, or improvement programs that allows for a reward, a contribution, a penalty, a differential in premiums, a differential in medical, prescription drug or equipment Copayments, Coinsurance, deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by the Plan or an entity chosen by the Plan to administer such programs. In addition, discount programs for various health and wellness-related or insurance-related items and services may be available from time to time. Such programs may be discontinued without notice. Contact the Plan for additional information regarding any value-based programs offered by the Plan. Contact your employer for additional information regarding any value-based programs offered by your employer.

As a member, the Plan makes available, at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by the Plan's designated outside vendor and acceptance or declination of these services is optional to members. 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 the Plan 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 Certificate.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan shall, at its own expense, have the right and opportunity to examine the person of a covered 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.

PROHIBITION AGAINST SUBSTITUTION

The Plan cannot require you to substitute your Primary Care Physician during any Inpatient Hospital stay, such as with a Hospital Physician who is licensed to practice medicine in all its branches without the authorization of your Primary Care Physician.

MODIFICATION OF COVERAGE

The Plan may modify your Certificate as required or permitted by applicable law and may modify your Certificate at renewal as long as the modification is consistent with applicable state and federal law on a uniform basis. Should the Plan elect to uniformly modify, terminate or discontinue coverage under this Certificate, the Plan must provide 90 days advance notice to the Department of Insurance.

MEDICALLY NECESSARY DISPUTE RESOLUTION

A dispute resolution process must be established in which a Physician holding the same class of license as your Primary Care Physician, but not affiliated with either your Participating IPA or Participating Medical Group and is jointly selected by you and/or your Participating IPA or Participating Medical Group in the event of a dispute regarding the medical necessity of a service. The Plan shall be required to provide the services should the reviewing Physician determine services to be medically necessary.

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 Certificate, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnification on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Plan or its agent, and agrees that any such Provider, person, or other entity may furnish to the Plan or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Plan may furnish similar information and records (or copies of records) to Providers, other Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Plan and/ or your employer or group administrator information regarding you or your dependents becoming eligible for Medicare, termination of Medicare eligibility, or any change in Medicare eligibility status, in order that the Plan be able to make Claim Payments in accordance with MSP laws.

MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, by the Host Blues whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by your Group, but solely as a result of a reduction in force, plant/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Blue Cross and Blue Shield of Illinois offers to, you, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, Blue Cross and Blue Shield of Illinois may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Policy the Group has with Blue Cross and Blue Shield of Illinois to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

OVERPAYMENT

If the Plan pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error (“overpayment”), the Plan has the right to obtain a refund of the overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any other insurance company or plan, or (iii) any other persons, entities, or organizations.

If no refund is received, the Plan may deduct any refund due to it, from:

1. Any future benefit payment made to any person or entity under this Certificate, whether for the same or a different member; or,

2. Any future benefit payment made to any person or entity under another Plan administered ASO benefit program; or

3. Any future benefit payment made to any person or entity under another Plan insured group benefit plan or individual policy; or,

4. Any future benefit payment, or other payment, made to any person or entity; or,

5. Any future payment owed to one or more participating or non-participating Providers.

Further, the Plan has the right to reduce your benefit plan's or policy's payment to a Provider by the amount necessary to recover another Plan's or policy's overpayment to the same Provider and to remit the recovered amount to the other Plan or policy.

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DEFINITIONS

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. The definitions of these words are listed below in alphabetical order. **These defined words will always be capitalized when used in this Certificate.**

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

Acute Treatment Services means a 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include bio-psychosocial assessment, individual and group counseling, psychoeducational groups and discharge planning.

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

Approved Clinical Trial means a phase I, phase II, or phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

1. A federally funded or approved trial,

2. A clinical trial conducted under an FDA investigational new drug application, or

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

Autism Spectrum Disorder(s) means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including Asperger's disorder and pervasive developmental disorders not otherwise specified.

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

Behavioral Health Practitioner means a Physician or professional Provider who is duly licensed to render services for the treatment of Mental Illness, or Substance Use Disorder and is operating within the scope of such license.

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

Certificate means this booklet and your application for coverage under the Plan benefit program described in this booklet.

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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.

Certified Nurse Midwife means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; 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 a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

Certified Nurse Practitioner means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and Hospital referral and (c) meets the following qualifications:

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.

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

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

Chiropractor means a duly licensed chiropractor.

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

Claim means notification in a form acceptable to the Plan that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Plan may request in connection with services rendered to you.

Claim Charge means the amount which appears on a Claim as the Provider's or supplier's charge for goods or services furnished to you, without adjustment or reduction and regardless of any separate financial arrangement between the Plan and a particular Provider or supplier. (See provisions of this Certificate regarding ``Plan's Separate Financial Arrangements with Providers.")

Claim Payment means the benefit payment calculated by the Plan, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Provider's Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Plan and a particular Provider. (See provisions of this Certificate regarding “Plan's Separate Financial Arrangements with Providers.”)

Clinical Appeal means an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care Provider that do not meet the definition of an Urgent/Expedited Clinical Appeal.

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

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 P.L. 99-272, as amended which regulate the conditions and manner under which an employer can offer continuation of group health insurance to employees and their family members whose coverage would otherwise terminate under the terms of this Certificate.

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

Coordinated Home Care Program means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. 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.)

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.

Continuous Ambulatory Peritoneal Dialysis Treatment means a continuous dialysis process using a patient's peritoneal membrane as a dialyzer.

Copayment means a specified dollar amount or Coinsurance that you are required to pay towards a Covered Service.

Coverage Date means the date on which your coverage under this Certificate begins.

Covered Service means a service or supply specified in this Certificate 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 or professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non- professional personnel, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications etc.) and are to assist with activities of daily living, (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

Dentist means a duly licensed dentist.

Dependent means an Eligible Person’s spouse, party to a Civil Union, Domestic Partner. parent or stepparent, or any Child(ren) covered under this Certificate.

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

Diagnostic Service means tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, computed tomography ("CT scans"), magnetic resonance imaging ("MRI") and positron emission tomography ("PET scans").

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

Domestic Partner means a person with whom you have entered into a Domestic Partnership.

Domestic Partnership means a long-term committed relationship of indefinite duration with a person which 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. Both you and your Domestic Partner are at least 18 years of age and mentally competent to consent to contract;
4. You and your Domestic Partner reside together and intend 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.

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

Electroconvulsive Therapy means a medical procedure in which a brief application of an electric stimulus is used to produce a generalized seizure.

Eligible Charge in the case of a Provider, other than a Physician, which has a written agreement with the Plan or another Blue Cross and/or Blue Shield Plan to provide care to participants in the health care plan, 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.

In addition to the foregoing, the Eligible Charge will be subject in all respects to the Plan's Claim Payment rules, edits and methodologies regardless of the Provider's status as a participating Provider or non-participating Provider. Please refer to the Plan's Separate Financial Arrangements with Providers provision in the OTHER THINGS YOU SHOULD KNOW section of this Certificate.

Eligible Person means an employee of the Group who meets the eligibility requirements for this health coverage, as described in the ELIGIBILITY section of this Certificate.

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 individual, the health of the individual or their 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 for a pregnant individual 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 individual or unborn child.

Examples of symptoms that may indicate the presence of an Emergency Medical Condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

Emergency Services means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered Inpatient and Outpatient Hospital services furnished by a Provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Medical Condition.

Enrollee means the person who has applied for coverage under this Certificate and to whom the Plan has issued an identification card.

Enrollment Date means the first day of coverage under your Group's health plan or, if your Group has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins). No such waiting period may exceed 90 days unless permitted by applicable law. If our records show that your Group has a waiting period that exceeds the time period permitted by applicable law, then we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your Group is responsible for your waiting period. If you have questions about your waiting period, please contact your Group.

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

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

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

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 facility 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 by the plan in assessing Experimental/Investigational status or 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 that your application for coverage was for yourself and other eligible members of your family.

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

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

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 with the scope of such license.

Hospice Care Program means a centrally administered program designed to provide physical, psychological, social and spiritual care for terminally ill persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program service is available in the home, or in Inpatient Hospital or Skilled Nursing Facility special hospice care unit.

Hospice Care Program Provider means an organization duly licensed to provide Hospice Care Program service when operating within the scope of such license.

Hospital means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

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

Individual Coverage means that your application for coverage was only for yourself.

Infusion Therapy means the administration through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

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

Life Threatening Disease or Condition means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Long Term Antibiotic Therapy means the administration of oral, intramuscular, or intravenous antibiotics singly or in combination for periods of time in excess of 4 weeks.

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

Maintenance Care means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or **Maintenance Speech Therapy** means therapy administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Marriage and Family Therapist means a duly licensed marriage and family therapist operating within the scope of such license.

Medical Care means the ordinary and usual professional services rendered by a Physician, Behavioral Health Practitioner, or other specified Provider during a professional visit, for the treatment of an illness or injury.

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

Medicare Secondary Payer or MSP means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

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

Naprapath means a duly licensed naprapath.

Naprapathy Services means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

Non-Clinical Appeal means an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

Occupational Therapy means a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

Ongoing Course of Treatment see provision for “CONTINUITY OF CARE”.

Optometrist means a duly licensed optometrist.

Outpatient means that you are receiving treatment while not an Inpatient.

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

Participating IPA means any duly organized Individual Practice Association of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

Participating Medical Group means any duly organized group of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

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

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

Physical Therapy means the treatment by physical means by or under the supervision of a qualified physical therapist.

Physician means a Physician duly licensed to practice medicine in all of its branches operating within the scope of such license.

Physician Assistant means a duly licensed Physician assistant performing under the direct supervision of a Physician.

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Podiatrist means a duly licensed podiatrist.

Policy means the agreement between the Plan and the Group, including the Certificate, any addenda or riders that apply, the Benefit Program Application of the Group and the individual applications, if any, of the persons covered under the Policy.

Participating Medical Group means any duly organized group of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program that has been designated as a Participating Medical Group.

Prescription Drug Provider means any Pharmacy which regularly dispenses drugs.

1. Participating Prescription Drug Provider means a Preferred or Non-Preferred Pharmacy, including but not limited to, an independent retail Pharmacy, chain or retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy that has a written agreement with the Plan, or with the entity chosen by the Plan to administer its prescription drug program, to provide Covered Services at the time rendered.

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

Primary Care Physician (PCP) means a Provider who is a member or employee of or who is affiliated with or engaged by a Participating IPA or Participating Medical Group and who is a) a Physician who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics, psychiatry or family practice, or b) a Chiropractor, and who you have selected to be primarily responsible for assessing, treating or coordinating your health care needs.

Private Duty Nursing Service means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing Service does not include Custodial Care Service.

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

Provider's Charge means a) in the case of your Primary Care Physician or another Physician who is affiliated with your Participating IPA/Participating Medical Group, the amount that such Physician would have charged for a good or service had you not been enrolled under this benefit program or b) in the case of a Provider or supplier which is not affiliated with your Participating IPA/Participating Medical Group, such Provider's or supplier's Claim Charge for Covered Services, unless otherwise agreed to by the Plan and the Provider or supplier.

Psychologist means:

1. a Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologist Registration Act" (111 Ill. Rev. Stat. §5301 et seq., as amended or substituted); or

2. in a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice;

3. or if practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Substance Use Disorder and who meets the following qualifications:

    a. has a doctoral degree from a regionally accredited University, College or Professional School and has two years of supervised experience in health services of which at least one year is postdoctoral and one year in an organized health services program; or

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

Radiation Therapy means the use of ionizing radiation in the treatment of a medical illness or condition.

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.

Renal Dialysis Treatment means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

Residential Treatment Center means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure medically necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

Respite Care Services means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services for you.

Routine Patient Costs means the cost for all items and services consistent with the coverage provided under this Certificate, that is typically covered for an Eligible Person who is not enrolled in a clinical trial.

Routine Patient Costs do not include:

1. The Investigational item, device or service, itself;

2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

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.

Skilled Nursing Service means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non- professional personnel. Skilled Nursing Service does not include Custodial Care Service.

Specialist Physician means a Provider with a contractual relationship or affiliation with the Participating IPA/Participating Medical Group who does not meet the definition of a Primary Care Physician, Woman's Principal Health Care Provider, or Behavioral Health Practitioner.

Speech Therapy means treatment for the correction of a speech impairment, including pervasive developmental disorders.

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 of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

Standing Referral means a written referral from your Primary Care Physician or Woman's Principal Health Care Provider for an Ongoing Course of Treatment pursuant to a treatment plan specifying needed services and timeframes as determined by your Primary Care Physician or Woman's Principal Health Care Provider, the consulting Physician or Provider and the Plan.

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

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

Substance Use Disorder Treatment Facility means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and which is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

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

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Temporomandibular Joint Dysfunction and Related Disorders means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking jawbone and skull and the complex of muscles, nerves and other tissues relating to that joint.

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.

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.

Totally Disabled means, with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or, with respect to an Enrollee other than the Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

Urgent/Expedited Clinical Appeal means an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatments ordered by a health care Provider that, if a decision is denied, may significantly increase the risk to your health.

Usual and Customary Fee means the fee as reasonably determined by the Plan which is based on the fee which the Provider who renders the service usually charges its patients for the same service and the fee which is within the range of usual fees other Providers of similar type, training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances.

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

Woman's Principal Health Care Provider (WPHCP) means a Physician licensed to practice medicine in all of its branches, specializing in obstetrics or gynecology or specializing in family practice.

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CONTINUATION COVERAGE FOR DISABLED OR RETIRED FIREFIGHTERS

NOTE: The CONTINUATION COVERAGE FOR DISABLED OR RETIRED FIREFIGHTERS applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Firefighter and surviving spouses or surviving parties to a Civil Union of such firefighter who are eligible for continued group health coverage under Section 367(f) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The firefighter, surviving spouse or surviving party to a Civil Union must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such firefighter, spouse or party to a Civil Union has Family Coverage, they may continue to have Family Coverage.

2. Group coverage can be continued until the firefighter, surviving spouse or surviving party to a Civil Union is no longer eligible, as specified in Section 367(f).

   (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse or surviving party to a Civil Union will end if such spouse or party to a Civil Union should remarry or enter another Civil Union. It is the employee/spouse's or surviving party to a Civil Union's responsibility to inform the Plan of their loss of eligibility.

3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the firefighter, surviving spouse or surviving party to a Civil Union.

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CONTINUATION COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

NOTE: The CONTINUATION COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Public employees and surviving spouses or surviving parties to a Civil Union of such employees who are eligible for continued group health coverage under Sections 367 (g), (h) and (i) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The public employee, surviving spouse or surviving party to a Civil Union must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such employee, spouse or party to a Civil Union has Family Coverage, they may continue to have Family Coverage.

2. Group coverage can be continued until the public employee, surviving spouse or surviving party to a Civil Union is no longer eligible, as specified in Sections 367 (g), (h) and (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse or surviving party to a Civil Union will end if such spouse or surviving party to a Civil Union should remarry or enter another Civil Union. It is the employee/spouse's or surviving party to a Civil Union's responsibility to inform the Plan of their loss of eligibility.

3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the public employee, surviving spouse or surviving party to a Civil Union.

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CONTINUATION COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES

NOTE: The CONTINUATION COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

If you are a full-time law enforcement, correctional or correctional probation officer, or firefighter and are eligible for continued group health insurance under the Public Safety Employee Benefits Act (820 ILCS 320), you may maintain such group health insurance under the following conditions:

1. You and your eligible dependents must have been insured under this Certificate on the day immediately preceding the date of eligibility for continued group health insurance.

2. Your Group shall pay the entire premium of the group health insurance coverage for you, your spouse, your party to a Civil Union and each dependent child until the child reaches the limiting age under this Certificate or until the end of the calendar year in which the child reaches the limiting age under this Certificate, whichever is later.

3. If you subsequently die, your Group shall continue to pay the entire health insurance premium for your surviving spouse or your surviving party to a Civil Union until he or she remarries or enters another Civil Union and for your dependent children under the conditions established in 2. above.

4. Health insurance benefits under this Certificate shall be reduced by health insurance benefits payable from any other source.

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