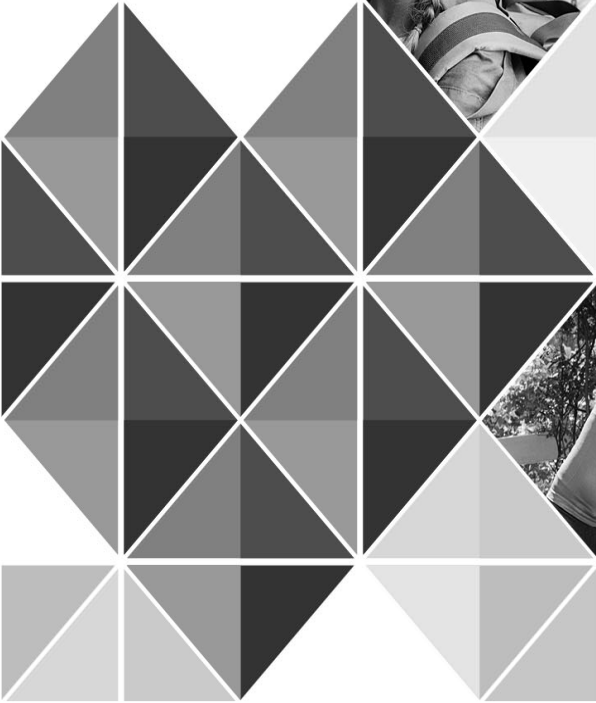




BlueCross BlueShield
of Illinois



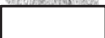
Your Health Care Benefits Program

Blue Cross Blue Shield HMO

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Blue Cross and Blue Shield of Illinois is
a Division of Health Care Service Corporation,
A Mutual Legal Reserve Company





BlueCross BlueShield of Illinois

A Division of Health Care Services Corporation,
A Mutual Legal Reserve Company
300 East Randolph
Chicago, IL 60601

CERTIFICATE AMENDMENT

This Amendment is issued to and made a part of your Group Managed Health Care Certificate of healthcare benefits with Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois herein called Blue Cross Blue Shield of Illinois.

The following changes are effective on the Employer's Contract Anniversary Date occurring on or after January 1, 2026, subject to the Illinois Department of Insurance approval.

IT IS AGREED that the Certificate to which this Amendment is attached, and becomes a part, is amended as stated below:

Unless otherwise required by Federal or state law, the terms of this Amendment supersede the terms of the Certificate to which this Amendment is attached and becomes a part of the Certificate.

"Certificate" means "Certificate" "Benefit Booklet," or "Member Guide" issued to you under the Group Certificate.

Terms that are capitalized are terms that are defined in your Certificate or this Amendment.

The following provisions are hereby amended, removed, replaced, or added to the Certificate:

I. Your Certificate and all attached amendments are uniformly modified as such:

All pronouns and gendered terms in the certificate or an associated amendment should be read as genderneutral, where appropriate and as the context requires. For example, "he" or "she" should be read as

Blue Cross Blue Shield of Illinois, a
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of the Blue Cross and Blue Shield Association

"they".

II. The following note is added under FAMILY COVERAGE within the ELIGIBILITY Section of your Certificate:

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 Services Area for this Certificate.

III. The following provisions are added or amended under the Covered Services within the PHYSICIAN BENEFITS Section:

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

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

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

1. surgical removal of completely bony impacted teeth;
2. excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth;
3. surgical procedures to 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; 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); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

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

- one baseline mammogram
- an annual mammogram

Benefits for 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 mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening, molecular breast imaging (MBI), and magnetic resonance imaging ("MRI") screening of an entire breast or breasts including breast tomosynthesis as determined by your Primary Care Physician or Woman's Principal Health Care Provider. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Certificate.

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.

Program deductible and will not be subject to any benefit period maximum or lifetime maximum.

Benefits for mammograms will be provided at 100% of the Provider's Charge, whether or not you have met your program deductible.

Blood Glucose Monitors for Treatment of Diabetes—Benefits are available for medically necessary blood glucose monitors (including continuous glucose monitors, non-invasive monitors and monitors for blind) If a Physician has written an order. This coverage also includes related supplies, and training in the use of continuous glucose monitors.

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

Therapies to Treat Menopause

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

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.

Menopause Health Visit

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

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.

Other Reproductive Services—Your coverage includes benefits for abortion care. will be provided at no cost.

Infertility Diagnosis and Treatment

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

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

The inability to conceive a Child or to carry a pregnancy to live birth after one year of regular.

1. Infertility means a disease, condition, or status characterized by; unprotected sexual intercourse for a woman 35 years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12-month or 6-month term for

determining Infertility);

2. A person's inability to reproduce either as a single individual or with a partner without medical intervention; or
3. A licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

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

Benefits for treatments that include oocyte retrievals will be provided only when you have been unable to attain or maintain a viable pregnancy or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless.

Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per Benefit Period, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered per Benefit Period.

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

Benefits 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.

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.

IV. In the Covered Services within the PHYSICIAN BENEFITS Section the following note is added:

MATERNITY SERVICES

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.

V. In the Covered Services within the PHYSICIAN BENEFITS Section the following is amended:

Maternity Service

If the newborn child needs treatment for an illness, injury, congenital defect (including Medically Necessary treatment of cleft lip and palate), birth abnormality or a 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.

VI. The following provisions are added or amended under the Covered Services within the HOSPITAL BENEFITS Section:

Other Reproductive Services—Your coverage includes benefits for abortion care. will be provided at no cost.

VII. The following provisions are added or amended under the Covered Services within the SUPPLEMENTAL BENEFITS Section:

Wigs Benefits will be provided for one wig every 12 months (also known as a cranial prostheses) when your hair loss caused by Chemotherapy, Radiation Therapy or alopecia.

VIII. The following provisions is amended under section SUBSTANCE USE DISORDER TREATMENT BENEFITS:

Your coverage includes benefits for the treatment of Substance Use Disorder. Benefits for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder includes pregnancy and postpartum periods and are available for those who have experienced a miscarriage stillbirth.

IX. In the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS the following note is added:

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.

X. In the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS the following provisions are added or replaced:

COVERED SERVICES

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

1. Has been approved by the FDA for the diagnosis and condition for which it was prescribed or
2. Has been approved by the FDA for at least one indication and is recognized 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.

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

Blood Glucose Monitors for Treatment of Diabetes

This plan provides benefits for Medically Necessary blood glucose monitors (including continuous glucose monitors, non-invasive monitors, and monitors for the blind), if a Physician has provided a written order.

This coverage also includes related supplies, and training in the use of continuous glucose monitors. Benefits for glucose monitors will be provided at no charge when obtained from a Participating Pharmacy.

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.

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

XI. In the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS the following provision is removed:

All references to “Step Therapy” requirements for covered prescription drugs are hereby removed.

XII. The following exclusions are added or amended under EXCLUSIONS WHAT IS NOT COVERED section:

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.

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 or 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.

XIII. The following definitions are added or amended in the DEFINITION SECTION:

Dependent means an Eligible Person’s spouse, part to a Civil Union, parent or stepparent, or any Child(ren) covered under this Certificate.

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;

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

Approval by a governmental or regulatory agency will be taken into consideration by the plan in assessing Experimental/Investigational status of a drug, device biological product, supply and equipment for medical treatment or procedure but will not be determinative.

Prescription drugs that are approved by the FDA through the accelerated approval program may be considered Experimental/Investigational.

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

Except as changed by this Amendment, all terms, conditions, limitations, and exclusions of the Certificate to which this Amendment is attached will remain in full force and effect.

GRANDFATHERED HEALTH PLAN DISCLOSURE

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at

P.O. Box 660819
Dallas, TX 75266-0819

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Blue Cross and Blue Shield of Illinois is
A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company

A handwritten signature in black ink that reads "Brian Snell". The signature is written in a cursive, flowing style.

Brian Snell, President,
Blue Cross Blue Shield of Illinois



BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company
300 East Randolph
Chicago, IL 60601

CERTIFICATE AMENDMENT

This Amendment is issued to and made a part of your Group Managed Health Care Certificate of healthcare benefits with Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois herein called Blue Cross Blue Shield of Illinois.

The following changes are effective on the Employer's Contract Anniversary Date occurring on or after January 1, 2026, subject to the Illinois Department of Insurance approval.

IT IS AGREED that the Certificate to which this Amendment is attached, and becomes a part, is amended as stated below:

Unless otherwise required by Federal or state law, the terms of this Amendment supersede the terms of the Certificate to which this Amendment is attached and becomes a part of the Certificate.

"Certificate" means "Certificate" "Benefit Booklet," or "Member Guide" issued to you under the Group Certificate.

Terms that are capitalized are terms that are defined in your Certificate or this Amendment.

The following provisions are hereby removed, replaced, or added to the Certificate:

- I. In the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS the following weblink and provision for Specialty Drugs are added:**

<https://www.bcbsil.com/il/documents/rx-drugs/specialty-drug-list-il.pdf>

In order to receive maximum benefits for Specialty Drugs, you must obtain the Specialty Drugs from a preferred Specialty Pharmacy Provider. When you obtain Specialty Drugs from a preferred Specialty Pharmacy Provider, benefits will be provided according to the payment provisions indicated in this Benefit Section for a Participating Pharmacy.

II. In your Certificate under EXCLUSIONS within the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS the following are added:

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

Some covered drugs, determined by the plan, may be available with no Member cost-share, to make these medications more affordable to Members.

Select medication may be excluded from the medical benefit when a self-administered formulation of the product is available.

III. In your Certificate the following exclusions are added under the section EXCLUSIONS WHAT IS NOT COVERED:

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

Select medication may be excluded from the medical benefit when a self-administered formulation of the product is available.

GRANDFATHERED HEALTH PLAN DISCLOSURE

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the

Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at

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You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

Except as changed by this Amendment, all terms, conditions, limitations, and exclusions of the Certificate to which this Amendment is attached will remain in full force and effect.

Blue Cross and Blue Shield of Illinois,
A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company

A handwritten signature in black ink that reads "Brian Snell". The signature is written in a cursive, flowing style.

Brian Snell, President,
Blue Cross Blue Shield of Illinois



BlueCross BlueShield of Illinois

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IT IS AGREED that the Certificate to which this Amendment is attached, and becomes a part, is amended as stated below:

Unless otherwise required by Federal or state law, the terms of this Amendment supersede the terms of the Certificate to which this Amendment is attached and becomes a part of the Certificate. However, definitions set forth in this Amendment are for purposes of this Amendment only.

"Certificate" means "Certificate," "Benefit Booklet," or "Member Guide" issued to you under the Group Certificate.

The section titles listed below are either the same section titles indicated in your Certificate, or other titled sections in your Certificate describing the same or similar benefits and provisions. Benefits will be payable for covered services indicated in this Amendment in accordance with the corresponding section title indicated in your Certificate.

Terms that are capitalized are terms that are defined in your Certificate or this Amendment.

The following provisions are hereby removed, replaced, or added to the Certificate:

I. The NON-PARTICIPATING PROVIDER NOTICE is replaced to read as follows:

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

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

II. The following provision are amended under the Maternity Services within the PHYSICIAN BENEFITS section of your Certificate as follows:

Maternity Service

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

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

1. The routine Inpatient Hospital nursery charges;
2. One routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery; and

3. One Inpatient hearing screening.

If the newborn child needs treatment for an illness, injury, congenital defect (including Medically Necessary treatment of cleft lip and palate), birth abnormality or a premature birth, benefits will be available for that care from the moment of birth, but 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.

III. The following provisions are replaced under the Covered Services within PHYSICAN BENEFITS section of your Certificate as follows:

Biomarker Testing

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

Ovarian Cancer Screening

Benefits will be provided for annual ovarian cancer screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Benefits will not be subject to any Deductible, Copayment or Coinsurance when services are received from a Participating Provider.

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or pap smear test. Benefits will not be subject to any Deductible, Copayment or Coinsurance when services are received from a Participating Provider.

Prostate Cancer Screening

Benefits will be provided for an annual routine Prostate Cancer Screening. Benefits will not be subject to any Deductible, Copayment or Coinsurance when services are received from a Participating Provider.

IV. The following provisions are added under the COVERED SERVICES within the PHYSICIAN BENEFIT section of your Certificate as follows:

Cleft Lip and Palate

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

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.

V. The following provisions are amended under the Maternity Services within the HOSPITALBENEFIT section of your Certificate as follows:

Maternity Service

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

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

1. The routine Inpatient Hospital nursery charges;
2. One routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery;and
3. One Inpatient hearing screening.

If the newborn child needs treatment for an illness, injury, congenital defect (including Medically Necessary treatment of cleft lip and palate), birth abnormality or a premature birth, benefits will be available for that care from the moment of birth, but 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.

VI. The following provisions are replaced under the Covered Services within SUPPLEMENTALBENEFITS section of your Certificate as follows:

Durable Medical Equipment

This plan provides benefits for Medically Necessary:

1. Internal cardiac valves;

2. Internal pacemakers;
3. Mandibular reconstruction devices (not used primarily to support dental prosthesis);
4. Bone screws, bolts, nails;
5. Compression sleeves to prevent or mitigate lymphedema;
6. Plates and any other internal and permanent devices.

This plan also provides benefits for:

1. The rental (but not to exceed the total cost of equipment); or
2. 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.

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 your Provider to be most appropriate for physical activities, such as running, biking, swimming, and lifting. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary

Prosthetic Appliances

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

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.

VII. The following provision are added under the Covered Services within SUPPLEMENTALBENEFITS section of your Certificate as follows:

Human Breast Milk

Benefits will be provided for pasteurized donated human breast milk,

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

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

Benefits will be provided for pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed medical practitioner, 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;

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

VIII. The following provision are added under the Covered Services within the OUTPATIENT PRESCRIPTION DRUGS PROGRAM BENEFIT section of your Certificate as follows:

Vaginal Estrogen

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

Prenatal Vitamins

Benefits will be provided for prenatal vitamins, when prescribed by a Physician or Advanced Practice Nurse.

IX. The following exclusion is hereby replaced under the Exclusion section within the OUTPATIENT PRESCRIPTION DRUGS PROGRAM BENEFIT section:

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.

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X. The following provision is hereby replaced in the section entitled HEARING AID BENEFITS:

Hearing Aids

This plan provides benefits for Medically Necessary Hearing Aids for covered persons 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 of 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

XI. The following exclusion under the section entitled EXCLUSIONS WHAT IS NOT COVERED is removed:

Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Certificate. Bone anchored hearing aids, cochlear implants and Hearing Aids for covered persons under the age of 18 may be covered as specific in the OTHER SERVICES or HEARING CARE PROGRAM sections of this Certificate.

XII. The following Definition is replaced under the Definition section of your Certificate as follows:

Hearing Aid means any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device including an ear mold but excluding batteries and cords.

Prostate Cancer Screening means medically viable methods for the detection and diagnosis of prostate cancer, including a digital rectal exam and the prostate-specific antigen test and associated laboratory work. This includes Medically Necessary subsequent follow-up testing directly by your Provider, including, but not limited to: 1) urinary analysis; 2) serum biomarkers; and 3) medical imaging (including magnetic resonance imaging).

XIII. The following benefit is replaced in the BENEFIT HIGHLIGHTS section of your Certificate:

HEARING BENEFITS

Hearing Aid benefits

- Number of Hearing Aids, per ear, each Benefit Period
- Benefit Period

One
24 months

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

Except as changed by this Amendment, all terms, conditions, limitations, and exclusions of the Certificate to which this Amendment is attached will remain in full force and effect.

GRANDFATHERED HEALTH PLAN DISCLOSURE

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at

P.O. Box 660819
Dallas, TX 75266-0819

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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Brian Snell, President,
Blue Cross Blue Shield of Illinois



BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company
300 East Randolph
Chicago, IL 60601

CERTIFICATE AMENDMENT

This Amendment is issued to and made a part of your Group Managed Health Care Certificate of healthcare benefits with Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois herein called Blue Cross Blue Shield of Illinois.

The following changes are effective on the Employer's Contract Anniversary Date occurring on or after January 1, 2025, subject to the Illinois Department of Insurance approval.

IT IS AGREED that the Certificate to which this Amendment is attached, and becomes a part, is amended as stated below:

Unless otherwise required by Federal or state law, the terms of this Amendment supersede the terms of the Certificate to which this Amendment is attached and becomes a part of the Certificate. However, definitions set forth in this Amendment are for purposes of this Amendment only.

"Certificate" means "Certificate," "Benefit Booklet," or "Member Guide" issued to you under the Group Certificate.

The section titles listed below are either the same section titles indicated in your Certificate, or other titled sections in your Certificate describing the same or similar benefits and provisions. Benefits will be payable for covered services indicated in this Amendment in accordance with the corresponding section title indicated in your Certificate.

Terms that are capitalized are terms that are defined in your Certificate or this Amendment.

The following provisions are hereby removed, replaced, or added to the Certificate:

I. The following exclusions are added or replaced in your Certificate under the EXCLUSIONS – WHAT IS NOT COVERED section:

- Drugs to treat sexual dysfunction.
- Cannabis - This plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing a delta-9-tetrahydrocannabinol (THC) concentration of more than three-tenths percent (0.3%) on a dry weight basis, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis plants with concentrations of THC above 0.3% may be called marijuana plants.

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

Except as changed by this Amendment, all terms, conditions, limitations, and exclusions of the Certificate to which this Amendment is attached will remain in full force and effect.

GRANDFATHERED HEALTH PLAN DISCLOSURE

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at P.O. Box 660819 Dallas, TX 75266-0819 You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Blue Cross and Blue Shield of Illinois,
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A Mutual Legal Reserve Company

A handwritten signature in black ink that reads "Brian Snell". The signature is written in a cursive, flowing style.

Brian Snell, President,
Blue Cross Blue Shield of Illinois



BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company
300 East Randolph
Chicago, IL 60601

CERTIFICATE AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan (Plan) occurring on or after January 1, 2022.

Note: Blue Cross Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross Blue Shield Association is herein called BCBSIL.

The terms of this Amendment supersede the terms of the Certificate to which this Amendment is attached and becomes a part of the Certificate. Unless otherwise required by Federal or Illinois law, in the event of a conflict between the terms of this Amendment and the terms of the Certificate, the terms of this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only.

I. The BALANCE BILLING AND OTHER PROTECTIONS provision is hereby deleted from this Certificate.

II. The following provisions are hereby added to the Certificate:

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, BCBSIL 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 PCP.

OB/GYN Care

You are not required to obtain a referral or authorization from your 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 Participating 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.

Continuity of Care

If you are receiving covered services from a Participating Provider or Participating Facility 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 elect to continue coverage for covered services from that provider or facility at the in-network benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the provider (including receipt of postoperative care from such provider or facility with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than ninety (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 Certificate.

Federal No Surprises Act Definitions

The definitions below apply only to this Amendment. To the extent the same terms are defined in both the Certificate and this Amendment, those terms will apply only to their use in the Certificate or this Amendment, respectively.

“Air Ambulance Services” means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

“Emergency Medical Condition” means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

“Emergency Services” means, for purposes of this Amendment only,

1. a medical screening examination performed in the emergency department of a hospital or an independent freestanding emergency department;
2. further medical examination or treatment you receive at a hospital, regardless of the department of the hospital, or an independent freestanding emergency department to evaluate and treat an Emergency Medical Condition until your condition is stabilized; and
3. Covered Services you receive from a Non-Participating Provider or Non-Participating Emergency Facility during the same visit after your Emergency Medical Condition has stabilized, or as part of outpatient observation or an inpatient or outpatient stay with respect to the same visit, unless:
 - a. your Non-Participating Provider or Non-Participating Emergency Facility determines you can travel by non-medical or non-emergency transport;
 - b. your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and
 - c. you have provided informed consent.

“Non-Participating Provider” means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan to which this Amendment is attached.

“Non-Participating Emergency Facility” means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan to which this Amendment is attached.

“Participating Provider” means, for purposes of this Amendment only, with respect to a covered service, a physician or other health care provider who has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached, regardless of whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

“Participating Facility” means, for purposes of this Amendment only, with respect to a covered service, a hospital or ambulatory surgical center that has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached, 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 subject Plan.

“Qualifying Payment Amount” means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

“Recognized Amount” means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

Federal No Surprises Act Surprise Billing Protections

1. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections (“Included Services”) are listed below.
 - Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
 - Covered non-emergency services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and

give up balance billing protections).

- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

2. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the provider or facility.

3. Cost-Sharing

For Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, and for non-emergency services performed by Non-Participating Providers at a Participating Facility, the Recognized Amount is used to calculate your cost-sharing 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-sharing requirements, including deductibles, copayments, and coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-sharing requirements will be counted toward your Participating Provider deductible and/or out-of-pocket expense limit, if any.

4. 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-sharing amount. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balance 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-sharing amounts. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a covered service, and such

services are provided by a Non- Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost-sharing amount. You cannot be balance billed for these Air Ambulance Services.

NOTICE

The Group Health Plan believes this coverage is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Contract/Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on Benefits for any individual.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status may be directed to the Employer or Group Administrator.

If the Group Health Plan is subject to the Employee Retirement Income Security Act (ERISA), requests for additional information may be directed to the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.

NOTE: The revisions to your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

Except as amended by this Amendment, all terms, conditions, limitations, and exclusions of the Certificate to which this Amendment is attached will remain in full force and effect.

Blue Cross and Blue Shield of Illinois is
A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company

A handwritten signature in dark ink, appearing to read "Stephen Harris", with a stylized flourish at the end.

Stephen Harris,
President,
Blue Cross Blue Shield of Illinois



BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company
300 East Randolph
Chicago, IL 60601

CERTIFICATE AMENDMENT

This Amendment is made a part of your 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, BCBSIL”) Certificate. The following changes are effective on the Certificate for all renewed plans on or after January 1, 2024, except as otherwise noted.

I. The GRANDFATHERED HEALTH PLAN DISCLOSURE is amended to read as follows:

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at

P.O. Box 660819
Dallas, TX 75266-0819

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866- 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

II. The address found within the How to Appeal an Adverse Benefit Determination section is replaced as follows:

Blue Cross Blue Shield of Illinois
P.O. Box 660603
Dallas, TX 75266-0603

III. The address found within the If You Need Assistance section is replaced as follows:

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.

Blue Cross Blue Shield of Illinois
P.O. Box 660603
Dallas, TX 75266-0603

GRANDFATHERED HEALTH PLAN DISCLOSURE

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at

P.O. Box 660819
Dallas, TX 75266-0819

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444- 3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Except as changed by this Amendment, all terms, conditions, limitations, and exclusions of the Certificate to which this Amendment is attached will remain in full force and effect.

Blue Cross and Blue Shield of Illinois is
A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company

A handwritten signature in black ink, appearing to read "Stephen Harris", with a stylized flourish at the end.

Stephen Harris,
President,
Blue Cross Blue Shield of Illinois



BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company
300 East Randolph
Chicago, IL 60601

HMO CERTIFICATE AMENDMENT

This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan (Plan) occurring on or after January 1, 2024, subject to the Illinois Department of Insurance approval.

This Amendment is issued to and made a part of your Group Managed Health Care Certificate of healthcare benefits with Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois herein called Blue Cross and Blue Shield of Illinois.

The Certificate to which this Amendment is attached, and becomes a part, is amended as stated below:

I. The NON-PARTICIPATING PROVIDER is amended to read as follows:

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

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such a Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.**

Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill except as provided

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in Section §356z.3a of the Illinois Insurance Code for Covered Services received at a Participating Facility from a Non-Participating Provider that are: (a) ancillary services, (b) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished, or (c) items or services received when the Participating Facility or the Non-Participating Provider fails to satisfy the notice and consent criteria specified under Section 356z.3a. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and Deductible amounts. You may obtain further information about the participating status of professional Providers and information on out-of-pocket expenses by calling the toll-free telephone number on your Identification Card.

II. The following provisions are added to the PHYSICIAN BENEFIT SECTION under COVERED SERVICES:

Breast Reduction Surgery

This plan provides benefits for Medically Necessary breast reduction surgery.

Hormone Therapy to Treat Menopause

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

III. The following is added to the HOSPITAL BENEFIT SECTION:

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.

IV. The following provisions have been added under the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION of your Certificate:

Intranasal Opioid Reversal Agent

This plan provides benefits for at least one intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50MME or higher.

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

Opioid Antagonists

This plan pays benefits for at least one opioid antagonist drug. This includes 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.

Hormone Therapy to Treat Menopause

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

Abortifacients

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

Hormonal Therapy for Gender Dysphoria

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

HIV Pre-Exposure Prophylaxis

Benefits will be provided at no charge for FDA-approved HIV pre-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.

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.

V. If your Certificate includes outpatient prescription drug coverage, any language in your Certificate stating “If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by you or on your behalf...” is hereby removed and replaced as follows:

If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket

expenses made by you or on your behalf, that amount will be applied to your program Deductible or out-of-pocket expense limit.

VI. If your Certificate includes an Exclusion for Outpatient Private Duty Nursing, it is hereby removed.

VII. Any Exclusions in your Certificate for male or female condoms it is hereby removed.

VIII. The following new Definition is added to the DEFINITIONS section:

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.

IX. The following Definition is amended to read as follows:

RESIDENTIAL TREATMENT CENTER....means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and onsite nursing care and supervision for at least one shift a day with the on call availability for patients with Mental Illness and/or Substance Use Disorders. Blue Cross and Blue Shield of Illinois requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, and/or accredited by a national organization that is recognized by Blue Cross and Blue Shield of Illinois as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

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

Except as amended by this Amendment, all terms, conditions, limitations, and exclusions of the Certificate to which this Amendment is attached will remain in full force and effect.

GRANDFATHERED HEALTH PLAN DISCLOSURE

This health insurance issuer believes this coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at P.O. Box 660819 Dallas, TX 75266-0819.

You may also contact the U.S. Department of Health and Human Services at <http://www.hhs.gov/>.

Blue Cross and Blue Shield of Illinois,
A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company



Stephen Harris,
President,
Blue Cross and Blue Shield of Illinois



BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company
300 East Randolph
Chicago, IL 60601

CERTIFICATE AMENDMENT

The following changes are effective on the Employer's Contract Anniversary Date occurring on or after January 1, 2024.

This Amendment is issued to and made a part of your Group Managed Health Care Certificate of healthcare benefits with Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois herein called Blue Cross Blue Shield of Illinois.

The Certificate to which this Amendment is attached, and becomes a part, is amended as stated below:

I. The following provision is added to your Certificate in reference to the Outpatient Prescription Drug Program Benefits:

Any cost shares for retail and mail order drugs will be based on day supply dispensed (Example: 1-30 day supply, 31-60 day supply, 61-90 day supply).

II. The following provisions are added to your Certificate in reference to the Outpatient Prescription Drug Program Benefits:

MedsYourWay™

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

The amount you pay for your Prescription will be applied, if applicable, to

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

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

Multi-Category Split-Fill Program

If this is Your first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if You have not filled one of these medications within 120 days, You may only be able to receive a partial fill (14–15 day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for You. If You receive a partial fill, Your Copayment Amount and/or Coinsurance Amount, after Your Deductible (if applicable), will be adjusted to align with the quantity of medication dispensed. If the medication is working for You and Your Physician wants You to continue on this medication, You may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply.

III. The following provision is replaced to your Certificate in reference to the Outpatient Prescription Drug Program Benefits:

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. Benefits in this Certificate may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Coverage for 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. For information about benefits for these drugs call the customer service toll-free telephone number located on your Identification Card. Early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use, and the early refills requested do not exceed the total number of refills prescribed by the Physician or Optometrist. Benefits for prescription inhalants will not be restricted on the

number of days before an inhaler refill may be obtained. However, you may receive coverage for up to a 12-month supply for dispensed contraceptive drugs and products that are covered under this Benefit Section. For additional information about early refills, please see the Prescription Refills provision below.

IV. The following exclusion is replaced to your Certificate in reference to the Outpatient Prescription Drug Program Benefits:

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

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

New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics' Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

V. If your Certificate includes an exclusion specific to Legend Drugs it is hereby removed.

GRANDFATHERED HEALTH PLAN DISCLOSURE

The Group Health Plan believes this coverage is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Contract/Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on Benefits for any individual.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status may be directed to the Employer or Group Administrator.

If the Group Health Plan is subject to the Employee Retirement Income

Security Act (ERISA), requests for additional information may be directed to the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.hhs.gov.

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

Except as amended by this Amendment, all terms, conditions, limitations, and exclusions of the Policy to which this Amendment is attached will remain in full force and effect.

Blue Cross and Blue Shield of Illinois,
A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company

A handwritten signature in black ink, appearing to read "Stephen Harris", with a stylized flourish at the end.

Stephen Harris,
President,
Blue Cross Blue Shield of Illinois

CERTIFICATE AMENDMENT

The Certificate to which this Amendment is attached, and becomes a part, is amended as stated below:

1. In the section entitled **PHYSICIANS BENEFITS**, the language is amended as follows:

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

2. In the **PHYSICIAN BENEFIT** section of this Certificate the following language has been amended:

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

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.

3. In the **HOSPITAL BENEFIT** section of this Certificate the following language has been added:

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.

4. In the **OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS** section of this Certificate the following language has been amended:

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/rx-drugs/drug-lists/drug-lists> . You may also contact a Customer Service Representative at the telephone number shown on the back of your Identification Card for more information.

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A handwritten signature in dark ink, appearing to read "Stephen Harris", with a stylized flourish at the end.

Stephen Harris
President,
Blue Cross and Blue Shield of Illinois

CERTIFICATE AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan occurring on or after January 1, 2022.

Note: Blue Cross Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross Blue Shield Association is herein called BCBSIL.

The terms of this Amendment supersede the terms of the Certificate to which this Amendment is attached and becomes a part of the Certificate. Unless otherwise required by Federal or Illinois law, in the event of a conflict between the terms on this Amendment and the terms of the Certificate, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any Member, including Subscriber and Dependents.

The following is hereby deleted from the Certificate:

- (i) In the **GENERAL PROVISIONS** section, the provision **BALANCE BILLING AND OTHER PROTECTIONS**.

The following is hereby added to the Certificate:

(ii) 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).

(iii) 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.

(iv) Continuity of Care

If You are under the care of a Participating Provider as defined in the 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:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Certificate.

(v) Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Certificate and this Amendment, those terms will apply only to their use in the Certificate or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

“Emergency Services” means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- Covered Services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
 1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
 2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
 3. You have provided informed consent.

“Non-Participating Provider” means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan to which this Amendment is attached.

“Non-Participating Emergency Facility” means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan to which this Amendment is attached.

“Participating Provider” means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

“Participating Facility” means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

“Qualifying Payment Amount” means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

“Recognized Amount” means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

- a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections (“Included Services”) are listed below.
- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
 - Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
 - Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.
- b. **Claim Payments**

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. **Cost-Sharing**

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your Participating Provider Deductible and/or out-of-pocket expense limit, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

(vi) GRANDFATHERED HEALTH PLAN DISCLOSURE

This health insurance issuer believes this coverage is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits for any individual. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to:

Blue Cross and Blue Shield of Illinois
P.O. Box 3236
Naperville, Illinois 60566-7236

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Except as amended by this Amendment, all terms, conditions, limitations, and exclusions of the Certificate to which this Amendment is attached will remain in full force and effect.

Blue Cross and Blue Shield of
Illinois, A Division of Health Care
Service Corporation, A Mutual
Legal Reserve Company

A handwritten signature in black ink, appearing to read 'Steve Harris', written over a horizontal line.

Steve Harris, President

CERTIFICATE AMENDMENT

The Certificate to which this Amendment is attached, and becomes a part, is amended as stated below:

1. In the section entitled **PHYSICIANS BENEFITS** and **BENEFIT HIGHLIGHTS** the followed is amended:

IL HMO plans will no longer have out of network, non-group approved, self-referred, non-emergent mental health/substance use benefits. This change will apply to all fully insured HMO's that currently have the self-referred benefit for mental health services.

2. In the section entitled **YOUR OVERALL DEDUCTIBLE**, the following language has been amended:

When your Group initially purchased this coverage, if you were a member of the Group at that time you are entitled to a special credit toward your program deductible and out of pocket expense limit for the first calendar year. This special credit applies to eligible expenses incurred for Covered Services within the prior contract's calendar year, if not completed. Such expenses can be applied toward the program deductible and out of pocket expense for the first calendar year under this coverage. However, this is only true if your Group had "major medical" type coverage immediately prior to purchasing this coverage.

3. In the section entitled **YOUR PRIMARY CARE PHYSICIAN**, the following language has been added: **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.

4. In the section entitled **PHYSICIANS BENEFITS**, the language is added as follows:

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

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

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

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

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

5. In the section entitled **PHYSICIAN BENEFITS**, the following language is added as follows:

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

Biomarker Testing - This plan provides benefits for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition.

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

Pancreatic Cancer Screening - This plan provides benefits for Medically Necessary pancreatic cancer screenings.

6. In the section entitled **PHYSICIAN BENEFITS**, the following language has been amended:

INFERTILITYmeans a disease, condition, or status characterized by:

1. The inability to conceive a child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman who is 35 years of age or younger, or after 6 months for a woman who is 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.

7. In the section entitled **HOSPITAL BENEFITS**, under Special Programs, the following paragraph is deleted:

Partial Hospitalization Treatment Program — This is a therapeutic treatment program in a Hospital for patients with Mental Illness. One day will be deducted

from your available Inpatient Mental Illness treatment days for every two days of care in a Partial Hospitalization Treatment Program.

8. In the section entitled **EMERGENCY CARE BENEFITS**, under In-Area Treatment of Emergency, the following paragraph is amended as follows:

You may go directly to the nearest Hospital emergency room to obtain treatment for an Emergency Medical Condition. If you are in your Participating IPA's/Participating Medical Group's treatment area, you should contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible, as long as it is not medically harmful or injurious to you.

Benefits will be limited to the initial treatment of your outpatient emergency 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.

9. In the section entitled **SUBSTANCE USE DISORDER TREATMENT BENEFITS**, the following paragraph is amended as follows:

Your coverage includes benefits for the treatment of Substance Use Disorder. Benefits for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder includes pregnancy and postpartum periods.

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

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 BlueAdvantage Network. To obtain benefits for Substance Use Disorder Treatment, they must be authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

10. In the section entitled **EXCLUSIONS**, the following language has been amended:

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

Certain services are covered pursuant to Blue Cross and Blue Shield 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 and herein called BCBS, medical policies and clinical procedure and coding policies, which are updated throughout the plan year. The medical policies are guides considered by Blue Cross and Blue Shield when making coverage determinations and lay out the procedure and criteria to determine whether a service, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is an exclusion under this Policy as set forth in this section, Exclusions—What Is Not Covered. The

clinical procedure and coding policies provide information about what services are reimbursable under the benefit plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsil.com, or by calling the phone number on the back of your identification card.

11. In the section entitled **EXCLUSIONS**, the following language has been deleted:
 - Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the EMEGENCY CARE BENEFITS section, PHYSICIAN BENEFITS section and HOSPITAL BENEFITS section of this Certificate.
12. In the section entitled **EXCLUSIONS**, the following language has been added:
 - Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your benefit, the drug purchased will not be covered under any Benefit level.
 - Drugs determined to have inferior efficacy or significant safety issues.
13. In the section **HOW TO FILE A CLAIM**, under the **Notice of Appeal Determination**, the following language has been added:

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.

14. In the section entitled **OTHER THINGS YOU SHOULD KNOW**, the following language has been added:

BALANCE BILLING and OTHER PROTECTIONS

Federal requirements, including but not limited to the Consolidated Appropriations Act, may impact your benefits. BCBSIL will apply federal requirements to your benefit plan, where applicable.

For some types of out-of-network care, your health care provider may not bill you more than your in-network cost-sharing levels. If you receive the types of care listed below, your cost-share will be calculated as if you received services from an in-network provider. Those cost-share amounts will apply to any in-network deductible and out-of-pocket maximums.

- Emergency care from facilities or providers who do not participate in your network;
- Care furnished by non-participating providers during your visit to an in-network facility; and
- Air ambulance services from non-participating providers, if your plan covers in-network air ambulance services.

There are limited instances when an out-of-network provider of the care listed above may send you a bill for up to the amount of that provider's billed charges. You are only responsible for payment of the out-of-network provider's billed charges if, in advance of receiving services, you signed a written notice that informed you of:

- the provider's out-of-network status;
- in the case of services received from an out-of-network provider at an in-network facility, a list of in-network providers at the facility who could offer the same services;
- information about whether prior authorization or other care management limitations may be required in advance of services; and
- good faith estimate of the provider's charges.

Your provider cannot ask you to be responsible for paying billed charges for certain types of services, including emergency medicine, anesthesiology, pathology, radiology, and neonatology, and other specialists as may be defined by applicable law.

15. In the **DEFINITIONS** section of this Certificate the following provision has been added:

BIOMARKER TESTINGmeans 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.

INFERTILITYmeans the inability to conceive a child after one year of unprotected sexual intercourse or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy. a disease, condition, or status characterized by:

1. The inability to conceive a child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman who is 35 years of age or younger, or after 6 months for a woman who is 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

A licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

16. In the **DEFINITIONS** section of this Certificate the following provision has been removed:

“Serious Mental Illness”.....means a condition or disorder as classified in the current Diagnostic and Statistical Manual published by the American Psychiatric Association:

- (i) Schizophrenia;
- (ii) Paranoid and other psychotic disorders;
- (iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) Major depressive disorders (single episode or recurrent);
- (v) Schizoaffective disorders (bipolar or depressive);
- (vi) Pervasive developmental disorders;
- (vii) Obsessive-compulsive disorders;
- (viii) Depression in childhood and adolescence;
- (ix) Panic disorder; and
- (x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- (xi) Eating disorders, including, but not limited to, anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

Serious Mental Illness....See definition of Mental Illness.

17. In the **BENEFITS HIGHLIGHTS** section of this Certificate the following provision has been amended:

- 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) \$30 per Visit
- Your Cost for Outpatient Specialist Physician Visits
(Including Mental Illness and Substance Use Disordered Treatment) \$50 per Visit
- Your Cost for Outpatient Office Visits for the Treatment of Mental Illness and Substance Use Disorder Treatment \$30 per Visit
- Your Cost for Outpatient Specialist Physician Visits for the Treatment of Mental Illness and Substance Use Disorder Treatment \$30 per Visit
- Your Cost for Telehealth Office Visits for the Treatment of Mental Illness and Substance Use Disorder Treatment \$30 per Visit
- Your Cost for Telehealth Specialist Physician Visits for the Treatment of Mental Illness and Substance Use Disorder Treatment \$50 per Visit

HOSPITAL BENEFITS

- Your Cost for Inpatient Covered Services
(Including Mental Illness) None
- Your Cost for Outpatient Covered Services
(Including Mental Illness) None

SUBSTANCE USE DISORDER TREATMENT BENEFITS

- Your Cost for Inpatient
Substance Use Disorder
Treatment None
- Your Cost for Outpatient
Specialist Physician Office Visits
for Substance Use Disorder
Treatment \$30 per Visit

Blue Cross and Blue Shield of Illinois,
A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company



Stephen Harris, President

HMO GROUP CERTIFICATE RIDER

This Certificate, to which this Rider is attached to and becomes a part of, is amended as stated below.

- A.** All references to “Chemical Dependency” are hereby replaced with the term “Substance Use Disorder”.

B. HOW TO FILE A CLAIM

The following provisions replace any appeals procedures described throughout the **HOW TO FILE A CLAIM** section of your Certificate:

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:

- a.** The reasons for determination;
- b.** A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;
- c.** A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- d.** Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable)

- e. An explanation of the Plan's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- f. 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);
- g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Plan;
- h. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- i. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the 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;
- k. 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
- l. Contact information for applicable office of health insurance consumer assistance or ombudsman.

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:

- Claims
- 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 of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the 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.

- a. **Urgent Care Clinical Claim** is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
- b. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
- c. **Post-Service Claim** is notification in a form acceptable to the 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
<i>The Plan must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
after receiving the completed Claim (if the initial Claim is incomplete), within:	24 hours of receipt of completed Claim

* 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
<i>The Plan must notify you of the Claim determination (whether adverse or not):</i>	
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
<i>The Plan must notify you of any adverse Claim determination:</i>	
if the initial Claim is complete, within:	30 days*
after receiving the completed Claim (if the initial Claim is incomplete), within:	45 days

* .This period may be extended one time by the 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.

In addition, an Adverse Benefit Determination, also includes an “Adverse Determination.”

An **“Adverse Determination”** means:

- a. a 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.
- b. a rescission of coverage determination, which does not include a cancellation of discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

For purposes of this benefit program, we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

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.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care Provider may appeal on his/her own behalf. 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.

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:

- 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. You may call 1-800-538-8833 or send your request to:

Claim Review Section
Health Care Service Corporation
P. O. Box 805107
Chicago, Illinois 60680-4112

- 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.

No deference will be given to the initial Adverse Benefit Determination. 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. 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 (if the appeal is related to health care services and not related to administrative matters or Complaints) or 30 days after the appeal has been received by the Plan, whichever is sooner.

The Plan will render a decision of a post-service appeal as soon as practical, but in no event more than 15 business days after receipt of all required information (if the appeal is related to health care services and not related to administrative matters or Complaints) or 60 days after the appeal has been received by the Plan, whichever is sooner.

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, of its determination, in writing (and orally in some situations).

The written notice to you or your authorized representative will include:

- a. The reasons for the determination;
- b. A reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
- c. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable);
- d. An explanation of the Plan's external review processes (and how to initiate 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 appeal;

- e. 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);
- f. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Plan;
- g. 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;
- h. 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;
- i. 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;
- j. A description of the standard that was used in denying the Claim and a discussion of the decision; and
- k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

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.

If an appeal is not resolved to your satisfaction, you may appeal the Plan's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Plan of the appeal. 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.

The Illinois Department of Insurance can be contacted at:

Illinois Department of Insurance
Consumer Division
320 West Washington Street
Springfield, Illinois 62767

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.

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.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, IL 60680-4112

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.

4. Standard External Review

You or your authorized representative must submit a written request for a standard external independent review to the Director of the Illinois Department of Insurance (“Director”) within 4 months of receiving an Adverse Determination or Final Adverse Determination. 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 Director 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 a covered person 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 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 re-

ceipt 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 Dir-

ector, 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
<i>The Plan must notify you whether the request is complete and eligible for external review:</i>	
if the request is not complete the Plan shall notify you and include what information or materials are required within:	one business day 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 the Director, you or your authorized representative that a request is eligible for external review within:	one business day after the preliminary review
The Director shall assign an independent review organization (IRO) within:	1 business day after receipt of the notice

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)

5. 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 Pro-

vider 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 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 less 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 remed-

ies 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

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
<i>The Plan must immediately notify the Director, you or your authorized representative whether the request is complete and eligible for an expedited 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.</i>	
The Director shall assign an independent review 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
<i>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.</i>	
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 or your authorized representative:	as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the receipt of request.

External Review of Experimental or Investigational Treatment

Experimental or Investigational Treatment External Review	Timing
You may file a request with the Director for an external review after receipt of an Adverse Determination or a Final Adverse Determination within:	4 months after date of receipt

<i>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.</i>	
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 or your authorized representative and the Director whether the request is complete and eligible for external review within:	one business day
<i>When the Director receives notice that the request is eligible for external review, the Director shall:</i>	
assign an IRO and notify the Plan of the name of the IRO, within:	one business day
notify you or your authorized representative in writing of the request's eligibility and acceptance for external review and the name of the IRO, within:	one business day
If you are notified that your request for an external review has been accepted, you or your authorized representative may 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
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 requested health care service shall be covered within:	20 days
or, in the case of an expedited external review:	immediately, but in no event more than 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 or your authorized representative and the Plan within:	20 days
or, in the case of an expedited external review, within:	48 hours after receipt of the opinion of each clinical reviewer

C. OTHER THINGS YOU SHOULD KNOW

1. The **Other Blue Cross And Blue Shield Plans Separate Financial Arrangements With Providers** provision of the **OTHER THINGS YOU SHOULD KNOW** section of your Certificate is revised to read as follows:

OTHER BLUE CROSS AND BLUE SHIELD PLANS' SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

BlueCard

The Plan hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois (“Host Blue”) may have contracts similar to the contracts described above with certain Providers (“Host Blue Providers”) in their service area.

Under BlueCard, when you receive health care services outside of Illinois and from a Provider which does not have a contract with the Plan, the amount you pay, if not covered by a flat dollar Copayment, for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Plan.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified

group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this provision or require a surcharge, the Plan would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Out-of-Area Services

The Plan has a variety of relationships with other Blue Cross and/or Blue Shield Plans under their Licensed Controlled Affiliates (“Licensees”) referred to generally as “Inter-Plan Programs”. Whenever you obtain health care services outside of your Plan’s service area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside your Plan’s service area and the service area of your Participating IPA/Participating Medical Group, you will obtain care from health care providers that have a contractual agreement (i.e., are “Participating IPA’s/Participating Medical Groups”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from Non-Participating providers. The Plan’s payment practices in both instances are described below.

The Plan covers only limited health care services received outside of your Plan’s Participating IPA’s/Participating Medical Group’s service area. As used in this section, **Other Things You Should Know** “Out-of-Area Covered Services” include emergency care, urgent care and follow-up care obtained outside the geographic area of the Plan’s Participating IPA’s/Participating Medical Group’s service area. Any other services will not be covered when processing through any Inter-Plan Programs arrangements, un-

less authorized by your Primary Care Physician (“PCP”) or Women’s Principal Health Care Provider (“WPHCP”)

BlueCard® Program

Under the BlueCard Program, when you obtain Out-of-Area Covered Services, as defined above, from a health care Provider participating with a Host Blue, the Plan will remain responsible for fulfilling Blue Cross and Blue Shield’s contractual obligations. 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 Services, as defined above, from a health care provider participating with a Host Blue, where available. The participating Provider will automatically file a claim for the Out-of-Area Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Copayment amount, as stated in this Certificate.

Emergency Care Services:

If you experience a medical emergency while traveling outside the Plan’s the Participating IPA’s/Participating Medical Group’s service area, go to the nearest emergency facility, urgent care facility, or other health care Provider.

Whenever you access Covered Services outside your Plan’s the Participating IPA’s/Participating Medical Group’s service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue makes available to the 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, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Plan use[s] for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Plan would then calculate your liability for any Covered Services according to applicable law.

Non-Participating Healthcare Providers Outside The Plan's Service Area Liability Calculation

a. 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 Plan's 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.

b. Exceptions:

In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion, negotiate a payment with such Non-Participating Provider on an exception basis.

2. The following provision is hereby added:

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.

D. GRANDFATHERED HEALTH PLAN DISCLOSURE REQUIREMENT

This group health plan believes this is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Certificate may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits for any individual.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer or the Plan Administrator. You may also contact the Illinois Department of Insurance at (877) 527-9431 or <http://insurance.illinois.gov>.

If your health plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For non-federal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Certificate to which this Rider is attached will remain in full force and effect.

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

A handwritten signature in black ink that reads "Karen Atwood". The signature is written in a cursive style with a large, stylized 'K' and 'A'.

President

HMO GROUP CERTIFICATE RIDER

This Certificate, to which this Rider is attached to and becomes a part of, is amended as stated below.

A. PHYSICIAN BENEFITS

18. The following is added under the **Anesthesia** provision under the **Covered Services** provision of the **PHYSICIAN BENEFITS** section of your Certificate:

Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon's office, Hospital or Ambulatory Surgical Facility if you are under age 19 and have been diagnosed with an autism spectrum disorder or a developmental disability.

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

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

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

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

19. The second and third paragraphs of the **Mammograms** provision are revised to read as follows:

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

comprehensive ultrasound screening or magnetic resonance imaging (“MRI”) screening of an entire breast or breasts including breast tomosynthesis as determined by your Primary Care Physician or Woman’s Principal Health Care Provider. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Certificate.

20. The following provisions are hereby added to the **Covered Services** provision of the **PHYSICIAN BENEFITS** section of your Certificate:

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

HIV Screening and Counseling — Benefits will be provided for HIV screening and counseling and pre-natal HIV testing ordered by your Primary Care Physician or Women’s Principal Health Care Provider, including but not limited to orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

21. The second and fourth paragraphs under the **Infertility Treatment** provision are hereby revised to read as follows:

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

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); and

B. OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

1. The following provision is added under the **Covered Services** provision of the **OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS** section of your Certificate:

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.

2. The **Day Supply** provision under the **OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS** section of your Certificate is revised to read as follows:

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. Specialty Drugs are limited to a 30 day supply. 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.

C. HOW TO FILE A CLAIM

1. Item #3 under the **FILING OUTPATIENT PRESCRIPTION DRUG PROGRAM CLAIMS** provision is revised to read as follows:

Mail the completed Claim Form with attachments to:

Prime Therapeutics
P. O. Box 25136
Lehigh Valley, PA 18002-5136

2. From the **INITIAL CLAIMS DETERMINATIONS** portion through the end of the **HOW TO FILE A CLAIM** section is replaced with the following:

INITIAL CLAIMS DETERMINATIONS

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

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, you or your authorized representative shall be notified in writing of the following:

- a. The reasons for determination;
- b. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;
- c. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- d. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), 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.
- e. 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:
 - I. An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);
 - II. 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 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:
 - A decision about the medical need for or the experimental status of a recommended treatment;
 - A condition was considered pre-existing; or
 - Your health care coverage was rescinded.
 - III. 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;
 - IV. An explanation that you may ask for an expedited (urgent) external review if:
 - 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;
 - The Plan failed to give you a decision within 48 hours of your request for an expedited appeal; or
 - 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.
 - V. 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;

- VI. 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.
- f. 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);
 - g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Plan.
 - h. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
 - i. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
 - j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the 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;
 - k. 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
 - l. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:
For Complaints and general Inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(877) 527-9431 Toll-free phone_
(217) 558-2083 Fax number
complaints@ins.state.il.us Email address

[https://mc.insurance.illinois.gov/messagecenter .
nsf](https://mc.insurance.illinois.gov/messagecenter.nsf)

For external review requests:

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

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:

- Claims
- 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 of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the 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.

- Urgent Care Clinical Claim** is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods

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

- b. Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
- c. Post-Service Claim** is notification in a form acceptable to the 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
<i>The Plan must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
after receiving the completed Claim (if the initial Claim is incomplete), within:	48 hours

* You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the 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

<i>The Plan must notify you of the Claim determination (whether adverse or not):</i>	
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
<i>The Plan must notify you of any adverse Claim determination:</i>	
if the initial Claim is complete, within:	30 days*
after receiving the completed Claim (if the initial Claim is incomplete), within:	45 days

* This period may be extended one time by the 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.

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

CLAIM APPEAL PROCEDURES

Claim Appeal Procedures - Definitions

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including

any such denial, reduction, termination, or failure to provide 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.

In addition, an Adverse Benefit Determination, also includes an "Adverse Determination."

An "**Adverse Determination**" means:

- a. a 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;
- b. the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by the Plan or its designated utilization review organization that a preexisting condition was present before the effective date of coverage; or
- c. 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, the Plan 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 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.

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

- 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.
- 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.
- 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 805107
Chicago, Illinois 60680-4112
1-800-538-8833 Toll-free number
1-866-414-4258 Fax number
1-918-551-2011_Fax number__for
Urgent requests send a secure email by using our
message center by logging into Blue Access for
MembersSM ("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've already received the service.

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

Notice of Appeal Determination

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:

- a.** The reasons for the determination;
- b.** A reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
- c.** 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;
- d.** 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:
 - I.** An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);

II. 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 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:

- A decision about the medical need for or the experimental status of a recommended treatment;
- A condition was considered pre-existing;
- 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.

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

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

IV. 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.

- e. 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;
- f. 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);

- g.** In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Plan;
- h.** The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits;
- i.** Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- j.** An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- k.** A description of the standard that was used in denying the Claim and a discussion of the decision; and
- l.** When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;
- m.** 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;
- n.** 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;
- o.** 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;
- p.** A Request for External Review Form, Authorized Representative Form, (HCP) Health Care Provider Certification — Request for Expedited Review Form, and (HCP) Health Care Provider Certification — Experimental/Investigational Review Form; and
- q.** The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For Complaints and general Inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number

complaints@ins.state.il.us Email address
[https://mc.insurance.illinois.gov/messagecenter .
nsf](https://mc.insurance.illinois.gov/messagecenter.nsf)

For external review requests:

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

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.

For Complaints, the Illinois Department of Insurance can be contacted at:

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

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.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the 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 Toll-free phone

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9432, 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.

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 Unit
320 West Washington Street
Springfield, Illinois 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address
[https://mc.insurance.illinois.gov/messagecenter .
nsf](https://mc.insurance.illinois.gov/messagecenter.nsf)

You may submit additional information or documentation to support your request for the health care services. Within one business day after the date of receipt of the request, the IDOI will send a copy of the request to the Plan.

a. Preliminary Review. Within five business days of receipt of the request from the IDOI, the Plan will complete a preliminary review of your request to determine whether:

- You were a covered person 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;
- 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 IDOI, you and your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the IDOI, you and your authorized representative shall be notified by 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 IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the IDOI's decision shall be in accordance with the terms of your benefit program (unless such terms are inconsistent with applicable laws) and shall be subject to all applicable laws.

c. Assignment of IRO. When the IDOI receives notice that your request is eligible for external review following the preliminary review, the IDOI

will, within one business day after the receipt of the notice, a) assign an IRO on a random basis from those IROs approved by the IDOI; and (b) notify 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 IDOI 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 IDOI, 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 IDOI, the Plan, you and your authorized representative, if applicable, of its decision.

With respect to experimental or investigational services or treatments, the IRO will make a decision within 20 days after the date it receives the opinion of each clinical reviewer, which will be determined by the recommendation of a majority of the clinical reviewers.

The written notice will include:

1. A general description of the reason for the request for external review;
2. The date the IRO received the assignment from the IDOI;
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. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review.

The IRO is not bound by any Claim determinations reached prior to the submission of information to the IRO. The IDOI, you, your authorized representative, if applicable, and the Plan will receive written notice from the IRO. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance's Office of Consumer Health Insurance.

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
<i>The Plan must notify you whether the request is complete and eligible for external review:</i>	
if the request is not complete the Plan shall notify you and include what information or materials are required within:	one business day 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 the IDOI, you or your authorized representative that a request is eligible for external review within:	one business day after the preliminary review
The IDOI shall assign an independent review organization (IRO) within:	one business day after receipt of the notice

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 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 IDOI either orally (by calling the phone number) 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 IDOI shall immediately send a copy of the request to the Plan. The Plan shall immediately notify the IDOI, you and your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review. The Plan's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the IDOI's decision shall be in

accordance with the terms of the benefit program (unless such terms are inconsistent with applicable law) and shall be subject to all applicable laws.

Assignment of IRO. If your request is eligible for expedited external review, the IDOI shall immediately assign an IRO on a random basis from the list of IROs approved by the IDOI; and immediately notify the Plan of the name of the IRO.

Upon receipt from the IDOI 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 within 24 hours or additional information may accompany the request for an expedited independent external review. 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 IDOI, 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 or 5 days for expedited Experimental/Investigational treatment after the date of receipt of the request for an expedited external review), the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the IDOI, 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 IDOI, 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 less than five calendar days after being selected. Within 48 hours after the date it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing to the IDOI, 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 IDOI, 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. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance's Office of Consumer Health Insurance.

An external review decision is binding on 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

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
<i>The Plan must immediately notify the IDOI, you or your authorized representative whether the request is complete and eligible for an expedited external review or is ineligible for review and may be appealed to the IDOI. The IDOI may make a determination that the request is eligible for an expedited external review, notwithstanding the Plan's determination.</i>	
The IDOI shall assign an independent review 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

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 IDOI and you or your authorized representative:	as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the receipt of request.
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External Review of Experimental or Investigational Treatment

Experimental or Investigational Treatment External Review	Timing
You may file a request with the IDOI for an external review after receipt of an Adverse Determination or a Final Adverse Determination within:	4 months after date of receipt
<i>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 IDOI shall immediately notify the Plan and the time frames otherwise applicable to Expedited External Review shall apply.</i>	
After the receipt for an external review, the IDOI 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 or your authorized representative and the IDOI whether the request is complete and eligible for external review within:	one business day
<i>When the IDOI receives notice that the request is eligible for external review, the IDOI shall:</i>	
assign an IRO and notify the Plan of the name of the IRO, within:	one business day
notify you or your authorized representative in writing of the request's eligibility and acceptance for external review and the name of the IRO, within:	one business day
If you are notified that your request for an external review has been accepted, you or your authorized representative may 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
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 requested health care service shall be covered within:	20 days

or, in the case of an expedited external review:	immediately, but in no event more than 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 IDOI, you or your authorized representative and the Plan within:	20 days
or, in the case of an expedited external review, within:	48 hours after receipt of the opinion of each clinical reviewer

D. DEFINITIONS

1. The definition of **Habilitative Services** has been revised to read as follows:

Habilitative Services 00means 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 your Physician pursuant to a treatment plan. Examples include Therapy for a child who isn't walking or talking at the expected age and includes Therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for an Eligible Person with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this Certificate.

2. The definition of **Substance Use Disorder** has been revised to read as follows:

Substance Use Disorder 00means those disorders classified as mental disorders in the edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association which is current as of the date services are rendered to a patient. Substance Use Disorders is the chemical dependency and/or the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

E. GRANDFATHERED HEALTH PLAN DISCLOSURE REQUIREMENT

This group health plan believes this is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Certificate may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered

health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits for any individual.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer or the Plan Administrator. You may also contact the Illinois Department of Insurance at (877) 527-9431 or <http://insurance.illinois.gov>.

If your health plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For non-federal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Certificate to which this Rider is attached will remain in full force and effect.

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)
Maurice Smith
BCBSIL Plan President

A handwritten signature in black ink, appearing to read "M. Smith", is written over a faint, circular, embossed or stamped seal. The seal is partially obscured by the signature and is located in the lower-left quadrant of the page.

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) to provide you with this 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 HMO. YOUR PRIMARY CARE PHYSICIAN OR WOMAN’S PRINCIPAL HEALTH CARE PROVIDER RENDERS AND COORDINATES YOUR MEDICAL CARE. YOUR BLUE CROSS 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,

A handwritten signature in black ink, appearing to read "Stephen Harris". The signature is fluid and cursive, with a long horizontal stroke extending to the left.

Stephen Harris

President

Blue Cross Blue Shield of Illinois

GRANDFATHERED HEALTH PLAN DISCLOSURE REQUIREMENT

This group health plan believes this is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Certificate may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits for any individual.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer or the Plan Administrator. You may also contact the Illinois Department of Insurance at (877) 527-9431 or <http://insurance.illinois.gov>.

If your health plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For non-federal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.

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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 been ordered by your Primary Care Physician (PCP) or Woman's Principal Health Care Provider (WPHCP), unless specified otherwise in this Certificate.

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) \$30 per Visit
- Your Cost for Outpatient Specialist Physician Visits
(Including Mental Illness and Substance Use Disorder Treatment) \$50 per Visit
- Your Cost for Outpatient Office Visits for the Treatment of Mental Illness and Substance Use Disorder Treatment \$30 per Visit
- Your Cost for Outpatient Specialist Physician Visits for the Treatment of Mental Illness and Substance Use Disorder Treatment \$30 per Visit
- Your Cost for Telehealth Office Visits \$30 per Visit
- Your Cost for Telehealth Office Visits for the Treatment of Mental Illness and Substance Use Disorder Treatment \$30 per Visit
- Your Cost for Telehealth Specialist Physician Office Visits \$50 per Visit

- Your Cost for Telehealth Specialist Physician Visits for Treatment of Mental Illness and Substance Use Disorder Treatment \$30 per Visit
- Your Cost for Outpatient Office Visits for the Treatment of Mental Illness \$30 per Visit
- Your Cost for Outpatient Office Visits for Periodic Health Examinations or Routine Pediatric Care \$30 per Visit
- Limit on Number of Chiropractic and Osteopathic Manipulation Visits None
- Limit on Number of Outpatient Rehabilitative Therapy Treatments 60 Treatments per Calendar Year

HOSPITAL BENEFITS

- Your Cost for Inpatient Covered Services (Including Mental Illness and Substance Use Disorder) None
- Your Cost for Inpatient Treatment of Mental Illness and Substance Use Disorder) 30% of the Eligible Charge, after your program deductible
- Your Cost for the Inpatient Treatment of Mental Illness and Substance Use Disorder None
- Your Cost for Outpatient Covered Services (Including Mental Illness and Substance Use Disorder) None

SUPPLEMENTAL BENEFITS

- Your Cost for Covered Services None

EMERGENCY CARE BENEFITS

- Your Cost for an In-Area Emergency \$150 Emergency Room Copayment (waived if admitted to Hospital as

- | | |
|--|---|
| | an Inpatient immediately following emergency treatment) |
| — Your Cost for an Out-of-Area Emergency | \$150 Emergency Room Copayment (waived if admitted to Hospital as an Inpatient immediately following emergency treatment) |

SUBSTANCE USE DISORDER TREATMENT BENEFITS

- | | |
|--|------------------------------------|
| — Your Cost for Inpatient Substance Use Disorder Treatment | None |
| — Your Cost for Inpatient Substance Use Disorder Treatment | \$30 Inpatient Copayment per visit |
| — Your Cost for Outpatient Office Visits for Substance Use Disorder Treatment | \$30 per Visit |
| — Your Cost for Outpatient Specialist Physician Office Visits for Substance Use Disorder Treatment | \$30 per Visit |

Refer to the **OTHER THINGS YOU SHOULD KNOW** section of your Certificate for information regarding Covered Services Expense Limitation.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

Please refer to the Outpatient Prescription Drug Program Benefit 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.

Note: The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$100, when obtained from a Preferred Participating or Participating Pharmacy.

- | | |
|---|-----------------------|
| — Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Participating in the 30-Day Supply Prescription Drug Program: | |
| — Tier 1 Generic Drugs and Generic Diabetic Supplies, insulin and insulin syringes | \$10 per Prescription |

- Tier 2 Preferred Brand-Name Drugs and Preferred Brand-Name Diabetic Supplies \$40 per Prescription
- Tier 3 Non-Preferred Brand-Name Drugs and Non-Preferred Brand-Name Diabetic Supplies \$60 per Prescription
- Self-Injectable Drugs other than Insulin and Infertility Drugs \$50 per Prescription
- Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Not Participating in the **30-Day Supply** Prescription Drug Program:

The appropriate Copayment(s) indicated above for drugs prescribed for emergency conditions.
- Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Participating in the **90-Day Supply** Prescription Drug Program:
 - Tier 1 Generic Drugs and Generic Diabetic Supplies, insulin and insulin syringes \$20 per Prescription
 - Tier 2 Preferred Brand-Name Drugs and Preferred Brand-Name Diabetic Supplies \$80 per Prescription
 - Tier 3 Non-Preferred Brand-Name Drugs and Non-Preferred Brand-Name Diabetic Supplies \$120 per Prescription
 - Self-Injectable Drugs other than Insulin and Infertility Drugs \$50 per Prescription
- Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Not Participating in the **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.

HEARING AID BENEFITS

- Hearing Aid benefits for individuals under 18
 - Benefit period 24 months

- Benefit Maximum None
- Number of Hearing Aids per ear, each benefit period One
- Hearing Aid benefits for individuals 18 or over
 - Benefit period 24 months
 - Benefit Maximum \$2,500 per ear per Benefit Period
 - Benefit payment level 100% of the Provider's Charge

**LIMITING AGE FOR
DEPENDENT CHILDREN 26**

ELIGIBILITY

The benefits described in this Certificate will be provided to persons who:

- Meet the definition of an Eligible Person as specified in the Group Policy;
- Have applied for this coverage;
- Have received a Blue Cross and Blue Shield identification card;
- Live within the Plan's service area. (Contact your Group or customer service at 1-800-892-2803 for information regarding service area.); and,
- If Medicare eligible, have both Part A and B coverage.

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

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

Totally Disabled dependents of an Eligible Person 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. 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 Disabled condition, are incapable of self-sustaining employment and are dependent upon the Eligible Person or other care providers for lifetime care and supervision.

Such Totally Disabled persons will be entitled to all of the benefits of this Certificate. Benefits will be coordinated with benefits under the prior group policy and the prior group policy will be considered the primary coverage for all services rendered in connection with the disability 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.

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) unmarried 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 unless specifically noted otherwise.

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

- Live within the Plan's service area; and

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

Coverage for unmarried children will end on the last day of the period for which premium has been accepted.

If you have Family Coverage, newborn children will be covered from the moment of birth as long as the Plan receives notice of the birth within 31 days of the birth. Your Group Administrator can tell you how to submit the proper notice.

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, will be covered. In addition, if you have children for whom you are required by court order to provide health care coverage, those children will be covered.

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

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

MEDICARE ELIGIBLE COVERED PERSONS

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

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

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

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

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

- Marriage.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Becoming party to a Civil Union.
- Loss of eligibility for other health coverage for you or your dependent if:
 - a. The other coverage was in effect when you were first eligible to enroll for 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.
- Termination of employer contributions towards you or your dependent's other coverage.
 - Exhaustion of COBRA continuation coverage or state continuation coverage.

WHEN COVERAGE BEGINS

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

- Marriage.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Becoming party to a Civil Union.
- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards you or your dependent's other coverage.
- Exhaustion of COBRA continuation or state continuation coverage.

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

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

- Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You can get the application form from 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

You will no longer be entitled to the health care benefits described in this Certificate when:

- You no longer meet the previously stated description of an Eligible Person; or
- The entire coverage of your Group terminates.

If one of your dependents becomes ineligible, his/her coverage will end as of the date the event occurs which makes him/her ineligible (for example, date of marriage, date of divorce) or a date determined by your Group. Coverage for a dependent child who reaches the limiting age will end as specified above under the heading "Family Coverage."

Your coverage (and the coverage of all of your family members) will be terminated, at the Plan's option, for failure to pay any required premium or charge, or for fraud or material misrepresentation in enrollment or in the use of services or facilities.

Benefits will not be provided for any services or supplies received after the date your coverage terminates under this Certificate unless specifically stated otherwise in the benefit sections of this Certificate or below under the heading

Extension of Benefits in Case of Discontinuance of Coverage. However, termination of your coverage will not affect your benefits for any services or supplies that you received prior to your termination date.

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.

Upon termination of your coverage under this Certificate, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of you or your dependent's coverage under this Certificate.

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 or lack of required Creditable Coverage for a preexisting condition. 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:

- Outpatient Prescription Drug Program Benefits

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA provision does not apply to your dependent who is a party to a Civil Union 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.

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:

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the 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's becoming 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 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 telephone number of the party responsible for administering your COBRA continuation coverage.

COVERAGE AFTER TERMINATION (Illinois State Laws)

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 himself/herself and his/her eligible 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 himself/herself and his/her 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.

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.
7. 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.
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.

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 himself/herself. 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.
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.

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. 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 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.

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 HMO. YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER RENDERS AND COORDINATES YOUR MEDICAL CARE. YOUR BLUE CROSS 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, treatment for Mental Illness or routine vision examinations. These benefits are explained in detail in the EMERGENCY CARE BENEFITS, HOSPITAL BENEFITS sections and, for routine vision examinations or Mental Illness 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's Participating IPA/Participating Medical Group/Woman's Principal Health Care Provider, if one has been selected, from the date of birth to the end of the month in which he/she is discharged from the Hospital. Your newborn may be added to the selected Participating IPA/Participating Medical Group on the first day of the month following discharge from the Hospital.

Changing Your Woman's Principal Health Care Provider

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

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

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.

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, (except for the treatment of Mental Illness) 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:

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

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

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

The following services are also part of your surgical benefits:

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

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

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

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

Autism Spectrum Disordermeans 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 Disabilitymeans a disability that is attributable to an intellectual disability or a related condition, if the related condition meets all of the following conditions:

- It is attributable to cerebral palsy, epilepsy or any other condition, other than a Mental Illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
 - It manifested before the age of 22;
 - It is likely to continue indefinitely; and
 - It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.
- **An assistant surgeon** — that is, a Physician, Dentist or Podiatrist who actively assists the operating surgeon in the performance of a covered surgical procedure.
 - **Additional Surgical Opinion** — following a recommendation for elective Surgery. Your benefits will be limited to one consultation and any related Diagnostic Service by a Physician.
 - **Surgery for morbid obesity** — including, but not limited to, bariatric Surgery.

Medical Care

Benefits will be provided for Medical Care rendered to you:

- when you are an Inpatient in a Hospital, Skilled Nursing Facility or a Residential Treatment Center;
- when you are a patient in a Home Health Care Program; or
- on an Outpatient basis in your Physician's office or your home.

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

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

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

- one baseline mammogram
- an annual mammogram

Benefits for mammogram will be provided for women under age 40 who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at the age and intervals considered medically necessary or as often as your Primary Care Physician or Woman's Principal Health Care Provider finds necessary.

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

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

Benefits for 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.

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.

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

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

Covered Services include, but are not limited to:

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

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

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

Benefits will also be provided for pre-school or school examinations that are required by state or federal law. Benefits are not available for recreational/camp physicals or sports physicals.

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

Allergy Testing and Treatment

Injected Medicines — that is, drugs that cannot be self-administered and which must be administered by injection. Benefits will be provided for the drugs and the administration of the injection. This includes routine immunizations and injections that you may need for traveling.

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

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

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

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

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

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

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

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

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.

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

Tobacco Use Screening and Smoking Cessation Counseling Services

Tobacco Use Cessation Drugs

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

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

professional with expertise in treating effects of Autism Spectrum Disorder(s) and when the care is determined to be medically necessary and ordered by your Primary Care Physician or Woman's Principal Health Care Provider:

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

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.

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

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

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

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.

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

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

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

Unless otherwise provided in this Certificate, benefits for Long-Term oral antibiotics used in the treatment of a Tick-Borne Disease are available under this benefit section.

Telehealth and Telemedicine Services

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

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

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

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

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

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

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

Dental Accident Care — that is, dental services rendered by a Dentist or Physician which are required as the result of an accidental injury. However, these

services are covered only if the injury is to sound natural teeth. A sound natural tooth is any tooth that has an intact root or is part of a permanent bridge.

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

Benefits 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.

Benefits are not available under this benefit section for the actual contraceptive drugs or for repeating or reversing sterilization.

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.

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

Experimental/Investigational Treatment — Benefits will be provided for routine patient care in conjunction with Experimental/Investigational treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your Physician is considered life-threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this 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.

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

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

Infertility Treatment

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

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

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

Benefits for treatments that include oocyte retrievals will be provided only when you have been unable to attain or maintain a viable pregnancy or sustain a successful pregnancy through reasonable, less costly medically appropriate 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 shall be covered per calendar year.

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, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
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.

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

Fertility Preservation Services

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

Temporomandibular Joint Dysfunction and Related Disorders

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

Mastectomy Related Services

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

Maternity Services

Your benefits for maternity services are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will be provided for delivery charges and for any of the previously described Covered Services when rendered in connection with pregnancy. For Family Coverage benefits will be provided for any treatment of an illness, injury, congenital defect, birth abnormality or a premature birth from the moment of the birth up to the first 31 days. You must notify the employee benefits department within 31 days of the birth so that the Health Care Plan records can be adjusted to add the newborn child to your Family Coverage. Premiums will be adjusted accordingly.

For Individual Coverage 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).

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

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

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

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been

authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, the Plan will neither provide benefits for such care nor coordinate benefits with any other health care coverage that you may have.

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

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 \$30 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, with no cost to you:

- Surgery;
- Chiropractic and osteopathic manipulation;
- Outpatient periodic health examinations;
- Routine pediatric care;
- Maternity services after the first pre-natal visit; and
- Routine vision examinations

Benefits for Outpatient office visits for periodic health examinations, routine pediatric care and routine vision examinations are subject to a Copayment of \$30 per visit and then will be paid in full.

Benefits for Outpatient visits to a Specialist Physician's office are subject to a Copayment of \$50 per visit and then will be paid in full.

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

- Physician
- Physician Assistant
- Certified Nurse Midwife
- Certified Nurse Practitioner
- Certified Registered Nurse Anesthetist
- Certified Clinical Nurse Specialist
- Marriage and Family Therapist

HOSPITAL BENEFITS

This section of your 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 semi-private room or a private room – must be ordered by your Primary Care Physician or Woman's Principal Health Care Provider.
 - an intensive care unit.
2. **Ancillary services** (such as operating rooms, drugs, surgical dressings and lab work).
3. **Rehabilitative Therapy** (including, but not limited to Physical, Occupational and Speech Therapy).

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

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

Number of Inpatient Days

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

Outpatient Benefits

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

1. **Surgery** — when performed in a Hospital or Ambulatory Surgical Facility. Benefits for Surgery also include Surgery for morbid obesity (including, but not limited to bariatric Surgery).
2. **Diagnostic Services** — that is, tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury.

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

Special Programs

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

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

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

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

determined to be medically necessary and ordered by your Primary Care Physician or Woman's Principal Health Care Provider:

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

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

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

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, birth abnormality or a premature birth, that care will be covered from the moment of birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage. Premiums will be adjusted accordingly.

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

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

except as may be indicated by the following: A shorter length of hospital inpatient stay related to maternity and newborn care may be provided if the

attending physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or by the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother and newborn. Such an earlier discharge may only be required if there 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.

Other Reproductive Services

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

URGENT CARE

This benefit provides medically necessary outpatient care if you are outside the 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

100% of the Provider's Charge will be paid when you receive the Covered Services of this benefit section, except as specifically mentioned below.

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.

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.

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:

- **Blood and Blood Components**
- **Outpatient Private Duty Nursing Service** — Benefits for Outpatient Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care Provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Outpatient Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long-term supportive care. Benefits for Outpatient Private Duty Nursing Service will not be provided due to the lack of willing or available non- professional personnel.
- **Medical and Surgical Dressings, Supplies, Casts and Splints**
- **Oxygen and its administration**
- **Naprapathic Service** — Benefits will be provided for Naprapathic Services when rendered by a Naprapath.
- **Prosthetic Devices** — Benefits will be provided for prosthetic devices, special appliances and surgical implants required for an illness or injury when:
 1. they are required to replace all or part of an organ or tissue of the human body; or
 2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

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

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

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

- **Orthotic Devices** — that is, a supportive device for the body or a part of the body, head, neck or extremities including, but not limited to leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition as determined by your Primary Care Physician or Woman's Principal Health Care Provider. Benefits for foot orthotics will be limited to a maximum of two devices or one pair of devices per calendar year..
- **Durable Medical Equipment** — that is, durable equipment which primarily serves a medical purpose, is appropriate for home use and generally is not useful in the absence of injury or disease. Benefits will be provided for the rental of a piece of equipment (not to exceed the total cost of equipment) or purchase of the equipment. Durable medical equipment must be rented or purchased from a Plan contracting durable medical equipment provider. Contact your Participating IPA/Participating Medical Group prior to purchasing or renting such equipment.

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

- **Wigs** — Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, Radiation Therapy or alopecia. Benefits for wigs will be limited to a maximum of per calendar year Benefits for wigs will be limited to a maximum of per Benefits for wigs will be limited to a lifetime maximum of one, two wig(s).

YOUR COST FOR COVERED SERVICES

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

You will be responsible for a Copayment of \$ per purchase or rental for the cost of the equipment, whichever is less, for durable medical equipment, thereafter your benefits will be paid in full at no cost to you.

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.

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.

If you obtain emergency treatment in the Hospital emergency room, your Primary Care Physician or Woman's Principal Health Care Provider must be notified of your condition as soon as possible and benefits will be limited to the initial treatment of your emergency 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.

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.

Should your visit to the emergency room of a Hospital immediately follow a visit from your employer's medical personnel, the emergency room Copayment will be waived whether or not you are admitted to the Hospital.

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. If you are not sure whether or not you are in your Participating IPA's/Participating Medical Group's treatment area, call them and they will tell you.

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.

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.

Should your visit to the emergency room of a Hospital immediately follow a visit from your employer's medical personnel, the emergency room Copayment will be waived whether or not you are admitted to the Hospital.

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.

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 BlueAdvantage Network.

INPATIENT BENEFITS

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

Cost To You For Outpatient Benefits

Benefits for Outpatient office visits for Substance Use Disorder Treatment are subject to a \$30 Copayment per visit and then will be paid at 100% of the Provider's Charge whether or not referred by your Primary Care Physician or Woman's Principal Health Care Provider.

In addition, benefits for Outpatient Substance Use Disorder Treatment visits to a Specialist Physician's office are subject to a Copayment of \$30 per visit and then will be paid in full whether or not referred by your Primary Care Physician or Woman's Principal Health Care Provider.

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.

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.

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 immunosuppressive drugs, donor screening and identification costs, under approved matched unrelated donor programs. Payment for Covered Services received will be the same as that specified in those benefit sections.

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

- If both the donor and recipient have coverage with the Plan, each will have his/her benefits paid by his or her own program.
- If you are the recipient and your donor does not have coverage from any other source, the benefits of 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.
- 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 one or two companion(s). For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

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

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

1. Organ transplants, and/or services or supplies rendered in connection with an organ transplant, which are Investigational as determined by the appropriate technological body.
2. Drugs which are Investigational.
3. Storage fees.

4. Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
5. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
6. Travel time or related expenses incurred by a Provider.
7. Meals.

HOSPICE CARE BENEFITS

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).

However, only one day will be deducted from the days available for Inpatient care in a Skilled Nursing Facility for every 2 days of Hospice Care Program service received in a Skilled Nursing Facility.

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

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

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

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

- (i) Which is medically necessary and is ordered by a Health Care Practitioner naming you as the recipient;
- (ii) For which a written or verbal Prescription is provided by a Health Care Practitioner;
- (iii) For which a separate charge is customarily made;
- (iv) Which is not consumed or administered at the time and place that the Prescription is written;
- (v) For which the FDA has given approval for at least one indication; and
- (vi) Which is dispensed by a Pharmacy and is received by you while covered under this Benefit Section, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the EXCLUSIONS provision later in this benefit section).

DRUG LIST.....means a list of all drugs that may be covered under this OUT-PATIENT PRESCRIPTION DRUG PROGRAM BENEFITS and related services section of this Certificate. A current list is available on our website at <https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists>. You may also contact a Customer Service Representative at the telephone number shown on the back of your identification card for more information.

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with 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 as the Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with the Plan or the entity chosen by the Plan to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

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

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

GENERIC DRUGmeans 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.

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 PROVIDERmeans 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 PROVIDERmeans 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 Prescription to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

PREFERRED PARTICIPATING PHARMACYmeans 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 SPECIALTY DRUGmeans a Specialty Drug that is identified on the Drug List as a Preferred Speciality Drug. The Drug List is found at the website stated in the *Customer Assistance* section.

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

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

ABOUT YOUR BENEFITS

Drug List

Drugs listed on the *Drug List* are selected by the Plan based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Plan. 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 step 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.

Your prescribing health care Provider, or your authorized representative, can ask for an exception if your drug is not on (or is being removed from) the Drug List if the drug requires prior authorization before it may be covered, or if the drug required as part of step therapy has been found to be (or likely to be) not right for you or does not work as well in treating your condition. To request this exception,

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 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 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 non covered drug, 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 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 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.

PRIOR AUTHORIZATION/STEP THERAPY REQUIREMENT

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

Step Therapy (ST): The Step Therapy program helps manage costs of expensive drugs by redirecting patients, when appropriate, to equally effective alternatives.

The program requires that Members starting a new drug treatment use a prerequisite drug first when appropriate. If the prerequisite drug is not effective, a targeted drug may then be acquired in the second step. You will be required to pay the applicable Copayment for the targeted drug. Although you may be currently on therapy, your request for a targeted drug may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a prerequisite drug may be required for continued coverage of the targeted drug.

To find out more about prior authorization/step therapy requirements or to determine which drugs or drug classes require prior authorization or step therapy, you should 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.

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

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.

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. Specialty Drugs are limited to a 30-day supply. For information on these drugs call the customer service toll-free number located on your identification card. However, early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the prescribing Physician or Optometrist. 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.

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.

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:

- The prescription drugs are covered under this Certificate or have received an exception approval as described under the **Drug List** provision above;
- The prescription drugs are maintenance medications and have refill quantities available to be refilled at the time of synchronization;
- the medications are not Schedule II, III, or IV controlled substances as defined in the Illinois Controlled Substances Act;
- All utilization management criteria (as described under the **Prior Authorization/ Step Therapy Requirement** provision above) for prescription drugs have been met;
- The prescription drugs can be safely split into short-fill periods to achieve synchronization; and
- The prescription drugs do not have special handling or sourcing needs that require a single, designated Pharmacy to fill or refill the Prescription.

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

COVERED SERVICES

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

1. Has been approved by the FDA for the diagnosis and condition for which it was prescribed or
2. Has been approved by the FDA for at least one indication and is recognized 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 brand names and have many therapeutic equivalents. In such cases, the Plan may limit benefits to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under this benefit section, the drug purchased will not be covered under any benefit level.

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

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

Injectable Drugs

Benefits are available for medically necessary injectable drugs which are self-administered that require a written prescription by federal law, 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 after an approved Human Organ Transplant.

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.

Self-Administered Cancer Medications

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

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.

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.

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 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.

Diabetic Supplies for Treatment of Diabetes

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

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

Compound Drugs

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

- (i) The drugs in the compounded product are FDA approved;
- (ii) The approved product has an assigned National Drug Code (NDC); and
- (iii) The primary active ingredient is a Covered Drug under this benefit section.

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

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

90-Day Supply Prescription Drug Program

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

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.

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

To 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.

30-Day Supply Prescription Drug Program

Benefit payment for the 30-day supply prescription drug program

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

When you purchase drugs or diabetic supplies from a Participating Prescription Drug Provider, you will not be charged any amount other than the specified Copayment amount, after you have met your program deductible. The Copayment amounts are shown in the **BENEFIT HIGHLIGHTS** section of this Certificate. You will be charged the Copayment amount for each prescription.

The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type shall not exceed \$100 when obtained from a Participating Pharmacy.

One prescription means up to a 30 consecutive day supply for most medications. Certain drugs may be limited to less than a 30 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.

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 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 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.

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.

EXCLUSIONS

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

1. Drugs 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.
4. Devices or durable medical equipment of any type (even though such devices may require a Prescription) such as, but not limited to, male condoms, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).
5. Pharmaceutical aids, such as, excipients found in the USP-NF (United States Pharmacopeia-National Formulary), including but not limited to, preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.).
6. Administration or injection of any drugs.

7. Vitamins (**except** those vitamins which by law require a Prescription and for which there is no non-prescription alternative).
8. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
9. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
10. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
11. 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. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by applicable laws and regulations or for the treatment of certain types of cancer when a particular legend drug has been shown to be effective for the treatment of that specific type of cancer even though that legend drug has not been approved for that type of cancer. The drug must have been shown to be effective for the treatment of that particular cancer according to the Federal Secretary of Health and Human Services.
15. 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.
16. Drugs, that the use or intended use of which would be illegal, abusive, not medically necessary, or otherwise improper.

17. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
18. 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.
19. 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.
20. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
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. Retin A or pharmacologically similar topical drugs for persons over the age of 40.
23. Athletic performance enhancement drugs.
24. Allergy serum and allergy testing materials.
25. Injectable drugs, except those determined by the Plan to be self-administered.
26. Some therapeutic equivalent drugs are manufactured under multiple names. In some cases, benefits may be to only one of the therapeutic equivalents available, as specified on the . If you do not choose the therapeutic equivalents that are covered under this benefits section, the drug purchased will not be covered under any benefit level.
27. Medications in depot or long acting formulations that are intended for use longer than the covered days supply amount.
28. Drugs determined by the Plan to have inferior efficacy or significant safety issues.
29. Devices and pharmaceutical aids.
30. Repackaged medications and institutional packs and drugs which are repackaged by anyone other than the other manufacturer.
31. Surgical supplies.
32. Ostomy products.
33. Diagnostic agents, except diabetic test strips.
34. General anesthetics.
35. Bulk powders.
36. Male condoms.

37. Any New-to-Market FDA-approved medications which are subject to review prior to coverage of the drug.
38. Drugs that are not considered medically necessary or treatment recommendation that are not supported by evidence-based guidelines or clinical practice guidelines.

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 for Individuals Under the Age of 18

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

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

Hearing Aids for Individuals Age of 18 or Over

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

Benefits are as follows:

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

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

Outpatient visits to your Primary Care Physician's office are subject to a Copayment of \$30 per visit and then will be paid in full.

Outpatient visits to a Specialist Physician's office are subject to a Copayment of \$50 per visit and then will be paid in full.

PRE-ADMISSION CERTIFICATION AND CONCURRENT REVIEW

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

PRE-ADMISSION CERTIFICATION

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

CONCURRENT REVIEW

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

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

EXCLUSIONS — WHAT IS NOT COVERED

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

Certain services are covered pursuant to Blue Cross and Blue Shield medical policies and clinical procedure and coding policies, which are updated throughout the plan year. The medical policies are guides considered by Blue Cross and Blue Shield when making coverage determinations and lay out the procedure and criteria to determine whether a service, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is an exclusion under this Policy as set forth in this section, Exclusions—What Is Not Covered. The clinical procedure and coding policies provide information about what services are reimbursable under the benefit plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsil.com, or by calling the phone number on the back of your identification card.

- Services or supplies that are not specifically stated in this Certificate.
- 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 Mental Illness or routine vision examinations, in the PHYSICIAN BENEFITS section of this Certificate.
- Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated.
- Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government whether or not those payments or benefits are received (except in the case of Medicare), except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.

- 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 or b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).
- Custodial Care Service.
- Long Term Care Services.
- Respite Care Services, except as specifically mentioned under Hospice Care Benefits.
- Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. However, this exclusion does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Special education therapy such as music therapy or recreational therapy, except as specifically provided for in this Certificate.
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease.
- Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form or charges for the transfer of medical records.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants except as specifically stated in this Certificate.
- Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient or unrelated to the treatment of a disease or injury.
- Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements, except as stated in this Certificate.

- Blood derivatives which are not classified as drugs in the official formularies.
- Hypnotism.
- Inpatient and Outpatient Private Duty Nursing Service.
- Routine foot care, except for persons diagnosed with diabetes.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate.
- Maintenance Care.
- Self-management training, education and medical nutrition therapy, except as specifically stated in this Certificate.
- Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.
- Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in this Certificate.
- Repair or replacement of appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.
- Services or supplies rendered for human organ or tissue transplants except as specifically provided for in this Certificate.
- Wigs (also referred to as cranial prostheses).
- Elective sterilizations, except as otherwise provided in the certificate.
- The reversals of sterilizations.
- Services or supplies rendered for infertility treatment except as specifically provided for in this Certificate.
- Eyeglasses, contact lenses or hearing aids, except as specifically provided for this Certificate.
- Dental care, except as directly required for the treatment of a medical condition or as otherwise provided for in this Certificate.
- Any services and/or supplies provided to you outside the United States, unless they are received for an Emergency Medical Condition, not withstanding any provision in the Certificate to the contrary.
- Male condoms.
- Benefits will not be provided for any self-administered drugs dispensed by a Physician.

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

Drugs determined to have inferior efficacy or significant safety issues.

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:

- (i) Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- (ii) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

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

CLAIM DETERMINATION PERIOD.....means a calendar year. However, it does not include any part of a year during which a person has no coverage

under this Benefit Program, or any part of a year before the date this COB provision or a similar provision takes effect.

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

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

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

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

ORDER OF BENEFIT DETERMINATION

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

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

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

1. Non-Dependent or Dependent

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

- a. Secondary to the Benefit Program covering the person as a dependent; and
 - b. Primary to the Benefit Program covering the person as other than a dependent, for example a retired employee.
- ### **2. Dependent Child if Parents not Separated or Divorced**

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

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

3. Dependent Child if Parents Separated or Divorced

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

- a. First, the program of the parent with custody of the child;
- b. Then, the program of the spouse of the parent with the custody of the child; and
- c. Finally, the program of the parent not having custody of the child.

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

4. Dependent Child if Parents Share Joint Custody

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

5. Young Adults as a Dependent

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

6. Active or Inactive Employee

The benefits of 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.

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 notwithstanding, 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.

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:

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, you or your authorized representative shall be notified in writing of the following:

- a. The reasons for determination;
- b. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;
- c. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- d. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), 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;

- e. 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:
- (i) An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);
 - (ii) 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:
 - A decision about the medical need for or the experimental status of a recommended treatment; or
 - Your health care coverage was rescinded.
 - (iii) 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;
 - (iv) An explanation that you may ask for an expedited (urgent) external review if:
 - 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;
 - The Plan failed to give you a decision within 48 hours of your request for an expedited appeal; or
 - 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.
 - (v) 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;
 - (vi) 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.

- f. 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);
- g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Plan.
- h. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- i. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the 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;
- k. 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
- l. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For complaints and general inquiries:

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

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 Email address
<https://mc.insurance.illinois.gov/messagecenter.nsf>

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:

- Claims
- 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 60601-5099**

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.

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

- b. Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
- c. Post-Service Claim** is notification in a form acceptable to the 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
<i>The Plan must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	48 hours
after receiving the completed Claim (if the initial Claim is incomplete), within:	48 hours

* You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the 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
<i>The Plan must notify you of the Claim determination (whether adverse or not):</i>	

Type of Notice or Extension	Timing
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
<i>The Plan must notify you of any adverse Claim determination:</i>	
if the initial Claim is complete, within:	30 days*
after receiving the completed Claim (if the initial Claim is incomplete), within:	45 days

* This period may be extended one time by the 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.

In addition, an Adverse Benefit Determination, also includes an “Adverse Determination.”

An “**Adverse Determination**” means:

- a. a 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.
- b. 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, the Plan 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 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.

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

- 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.
- 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.
- 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 805107
Chicago, Illinois 60680-4112
1-800-538-8833 Toll-free number
1-866-414-4258 Fax number
1-918-551-2011 Fax number for urgent requests
send a secure email by using our message center by
logging into Blue Access for Members (“BAM”) at
www.bcbsil.com

During the course of your internal appeal(s), 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've already received the service.

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

Notice of Appeal Determination

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:

- a. The reasons for the determination;
- b. A reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
- c. 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;

d. 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:

- (i) An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you’d like to add);
- (ii) 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:

- A decision about the medical need for or the experimental status of a recommended treatment;
- 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.

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

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

- (iv) 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.

- e. 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;
- f. 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);
- g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Plan;
- h. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits;
- i. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- j. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- k. A description of the standard that was used in denying the Claim and a discussion of the decision; and
- l. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;
- m. 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;
- n. 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;
- o. 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;
- p. A Request for External Review Form, Authorized Representative Form, (HCP) Health Care Provider Certification — Request for Expedited Review

Form, and (HCP) Health Care Provider Certification —
Experimental/Investigational Review Form; and

- q. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For complaints and general inquiries:

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

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 Email address
<https://mc.insurance.illinois.gov/messagecenter.nsf>

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.

For complaints, the Illinois Department of Insurance can be contacted at:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street

Springfield, Illinois 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
Consumer complaints@ins.state.il.us Email address
<https://mc.insurance.illinois.gov/messagecenter.nsf>
Website address

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.

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.

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 Unit Name of Department
320 West Washington Street
Springfield, Illinois 62767
(877) 850-4740 Phone number Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address
<https://mc.insurance.illinois.gov/messagecenter.nsf>
Website address

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;
- 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 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. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review.

The IRO is not bound by any Claim 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
<i>The Plan must notify you whether the request is complete and eligible for external review:</i>	
if the request is not complete the Plan shall notify you and include what information or materials are required within:	one business day 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 the Director, you or your authorized representative that a request is eligible for external review within:	one business day after the preliminary review
The Director shall assign an independent review organization (IRO) within:	one business day after receipt of the notice
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 within 24 hours or additional information may accompany the request for an expedited independent external review. 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 or 5 days for expedited Experimental/Investigational treatment 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 less 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. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance's Office of Consumer Health Insurance.

An external review decision is binding on 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

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
<i>The Plan must immediately notify the Director, you or your authorized representative whether the request is complete and eligible for an expedited 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.</i>	
The Director shall assign an independent review 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
<i>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.</i>	
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 or your authorized representative:	as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the receipt of request.

External Review of Experimental or Investigational Treatment

Experimental or Investigational Treatment External Review	Timing
You may file a request with the Director for an external review after receipt of an Adverse Determination or a Final Adverse Determination within:	4 months after date of receipt
<i>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.</i>	
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 or your authorized representative and the Director whether the request is complete and eligible for external review within:	one business day
<i>When the Director receives notice that the request is eligible for external review, the Director shall:</i>	
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
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
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

Experimental or Investigational Treatment External Review	Timing
or, in the case of an expedited external review:	immediately, but in no event more than 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 or your authorized representative and the Plan within:	20 days
or, in the case of an expedited external review, within:	48 hours after receipt of the opinion of each clinical reviewer

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:

- a. 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:
 - (i) 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
 - (ii) 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.
- b. the Plan is assigned the right to recover from the third party, or his or her 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:

- 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
- pay Providers or suppliers substantially less than their Claim Charges for goods or services, by discount or otherwise, or

- receive from Providers or suppliers other substantial allowances under the 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.

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 Women'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:

- The billed charges for your Covered Services, or
- 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 use[s] 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

a. 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.

b. 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:

1. 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
2. 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 the 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 BlueCard Worldwide® 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:

- a. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is \$100. How is the \$100 paid?
- b. You personally will have to pay the Coinsurance Amount set out in this Certificate.
- c. However, for purposes of calculating your Coinsurance amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the \$100 prescription drug bill would be reduced by 20% to \$80 for purposes of calculating your Coinsurance Amount.

- d. In our example, if your Coinsurance obligation is 25%, you 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.

For the 90-day 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.

"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 day's supply dispensed. A paid Claim is weighted in 34 day supply increments so a 1-34 day's 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.

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 and the 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.

BALANCE BILLING and OTHER PROTECTIONS

Federal requirements, including but not limited to the Consolidated Appropriations Act, may impact your benefits. BCBSXX will apply federal requirements to your benefit plan, where applicable.

For some types of out-of-network care, your health care provider may not bill you more than your in-network cost-sharing levels. If you receive the types of care listed below, your cost-share will be calculated as if you received services from an in-network provider. Those cost-share amounts will apply to any in-network deductible and out-of-pocket maximums.

- Emergency care from facilities or providers who do not participate in your network;
- Care furnished by non-participating providers during your visit to an in-network facility; and
- Air ambulance services from non-participating providers, if your plan covers in-network air ambulance services.

There are limited instances when an out-of-network provider of the care listed above may send you a bill for up to the amount of that provider's billed charges. You are only responsible for payment of the out-of-network provider's billed charges if, in advance of receiving services, you signed a written notice that informed you of:

- the provider's out-of-network status;
- in the case of services received from an out-of-network provider at an in-network facility, a list of in-network providers at the facility who could offer the same services;
- information about whether prior authorization or other care management limitations may be required in advance of services; and
- a good faith estimate of the provider's charges.

Your provider cannot ask you to be responsible for paying billed charges for certain types of services, including emergency medicine, anesthesiology, pathology, radiology, and neonatology, and other specialists as may be defined by applicable law.

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 \$1,500, 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 \$3,000, 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:

- Services, supplies or charges excluded under this Certificate
- charges for Outpatient prescription drugs
- charges for vision care benefits
- charges for hearing aids as described under the **HEARING AIDS BENEFITS** section of this Certificate

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

YOUR PROVIDER RELATIONSHIPS

The choice of a Hospital, Participating IPA, Participating Medical Group, Primary Care Physician or any other Provider is solely your choice and 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 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 Women's Principal Health Care Provider or other Provider who leaves the Plan's network for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by State licensing board, and your Provider

agrees, you may be able to continue receiving Covered Services with that Provider for the following:

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

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

If you are a new 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, or if you have entered the second or third trimester of pregnancy at the time of the provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery. The Plan may authorize transition of care benefits for a period up to 90 days from the effective date of enrollment. Authorization of benefits is dependent on the Physician's agreement to contractual requirements and submission of detailed treatment plan. A written notice of the Plan's determination will be sent to you within 15 business days of receipt of your request.

You have the right to appeal any decision made for a request for benefits under this provision as explained in the **CLAIM APPEAL PROCEDURES** provision in the **HOW TO FILE A CLAIM** section of this Certificate.

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 a 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:

- a. Any future benefit payment made to any person or entity under this Certificate, whether for the same or a different member; or,
- b. Any future benefit payment made to any person or entity under another Plan administered ASO benefit program; or
- c. Any future benefit payment made to any person or entity under another Plan insured group benefit plan or individual policy; or,
- d. Any future benefit payment, or other payment, made to any person or entity; or,
- e. Any future payment owed to one or more participating or non-participating Providers.

Further, the Plan has the right to reduce your benefit plan’s or policy’s payment to a Provider by the amount necessary to recover another Plan’s or policy’s overpayment to the same Provider and to remit the recovered amount to the other Plan or policy.

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.**

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

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

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

- a) A federally funded or approved trial,
- b) A clinical trial conducted under an FDA investigational new drug application, or
- c) A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Autism Spectrum Disorder(s).....means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including Asperger's disorder and pervasive developmental disorders not otherwise specified.

Behavioral Health Practitioner.....means a Physician or professional Provider who is duly licensed to render services for the treatment of Mental Illness, or Substance Use Disorder and is operating within the scope of such license.

Certificate.....means this booklet and your application for coverage under the Plan benefit program described in this booklet.

Certified Clinical Nurse Specialist.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and
- (ii) is a graduate of an advanced practice nursing program.

Certified Nurse Midwife.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and
- (ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

Certified Nurse Practitioner.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and
- (ii) is a graduate of an advanced practice nursing program.

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

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

Chiropractor.....means a duly licensed chiropractor.

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

Claim.....means 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.).

Dentist.....means a duly licensed dentist.

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, compute 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.

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

Electroconvulsive Therapy.....means a medical procedure in which a brief application of an electric stimulus is used to produce a generalized seizure.

Eligible Person.....means an employee of 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:

- a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- b) serious impairment to bodily functions;
- c) serious dysfunction of any bodily organ or part;
- d) inadequately controlled pain; or
- e) with respect for a pregnant woman who is having contractions:
 - 1. inadequate time to complete a safe transfer to another hospital before delivery or
 - 2. a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

Emergency Services.....means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered Inpatient and Outpatient Hospital services furnished by a Provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Medical Condition.

Enrollee.....means the person who has applied for 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).

Experimental/Investigational (also referred to as “Investigational”).....means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as “Standard Medical Treatment” of the condition being treated or any of such items requiring federal or other governmental agency approval not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

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

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

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

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.

Family Coverage.....means that your application for coverage was for yourself and other eligible members of your family.

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 within 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 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.

May Directly or Indirectly Cause.....means the likely possibility that treatment will cause a side effect of infertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

Medical Care.....means the ordinary and usual professional services rendered by a Physician, 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.

- (i) Schizophrenia;
- (ii) Paranoid and other psychotic disorders;
- (iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) Major depressive disorders (single episode or recurrent);
- (v) Schizoaffective disorders (bipolar or depressive);
- (vi) Pervasive developmental disorders;
- (vii) Obsessive-compulsive disorders;
- (viii) Depression in childhood and adolescence;
- (ix) Panic disorder; and
- (x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- (xi) Eating disorders, including, but not limited to, anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

Naprapath.....means a duly licensed naprapath.

Naprapathic 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 Programmeans 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.

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

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.

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.

Prescription Drug Provider.....means any Pharmacy which regularly dispenses drugs

- a) **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.
- b) **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 in to 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:

- a) a Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologist Registration Act" (111 Ill. Rev. Stat. §5301 et seq., as amended or substituted); or

- b) in a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice; or
- c) if practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Substance Use Disorder and who meets the following qualifications:
 - 1. has a doctoral degree from a regionally accredited University, College or Professional School and has two years of supervised experience in health services of which at least one year is postdoctoral and one year in an organized health services program; or
 - 2. is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College and has not less than six years experience as a psychologist with at least two years of supervised experience in health services.

Radiation Therapy.....means the use of ionizing radiation in the treatment of a medical illness or condition.

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 degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and that address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders.

Respite Care 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 a Eligible Person who is not enrolled in a clinical trial.

Routine Patient Costs do not include:

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

Skilled Nursing Facility.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Service.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

Specialist Physician.....means a Provider with a contractual relationship or affiliation with the Participating IPA/Participating Medical Group who does not meet the definition of a Primary Care Physician, Woman's Principal Health Care Provider, or Behavioral Health Practitioner.

Speech Therapy.....means treatment for the correction of a speech impairment, including pervasive developmental disorders.

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 time frames as determined by your Primary Care Physician or Woman's Principal Health Care Provider, the consulting Physician or Provider and the Plan.

Substance Use Disordermeans 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.

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

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

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

- (i) a severe infection with borrelia burgdorferi;
- (ii) a late stage, persistent, or chronic infection or complications related to such an infection;
- (iii) an infection with other strains of borrelia or a tick-borne disease that is recognized by the United States Centers for Disease Control and Prevention; and
- (iv) with the presence of signs or symptoms compatible with acute infection of borrelia or other Tick-Borne Diseases.

Totally Disabled.....means, with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or, with respect to an Enrollee other than the Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

Urgent/Expedited Clinical Appeal.....means an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your health.

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.

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, he/she 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 his/her loss of eligibility.
3. The total monthly premium for this continuation 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.

CONTINUATION COVERAGE FOR DISABLED OR RETIRED FIREMEN

NOTE: The CONTINUATION COVERAGE FOR DISABLED OR RETIRED FIREMEN applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Firemen and surviving spouses or surviving parties to a Civil Union of such firemen 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 fireman, 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 fireman, spouse or party to a Civil Union has Family Coverage, he/she may continue to have Family Coverage.
2. Group coverage can be continued until the fireman, surviving spouse or surviving party to a Civil Union is no longer eligible, as specified in Section 367 (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 his/her loss of eligibility.
3. The total monthly premium for this continuation 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 fireman, surviving spouse or surviving party to a Civil Union.

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.



BlueCross BlueShield of Illinois

A Division of Health Care Services Corporation, A Mutual Legal Reserve Company

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator

Attn: Office of Civil

Rights Coordinator

300 E. Randolph St., 35th Floor

Chicago, IL 60601

Phone: 855-664-7270 (voicemail)

TTY/TDD: 855-661-6965

Fax: 855-661-6960

Email: civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health &

Human Services

200 Independence Avenue SW

Room 509F, HHH Building

Washington, DC 20201

Phone: 800-368-1019

TTY/TDD: 800-537-7697

Complaint Portal:

ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Complaint Forms:

[hhs.gov/civil-rights/](https://hhs.gov/civil-rights/filing-a-complaint/index.html)

[filing-a-complaint/index.html](https://hhs.gov/civil-rights/filing-a-complaint/index.html)

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This notice is available on our website at
bcbsil.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.
中文 Chinese	注意: 如果您说中文, 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 855-710-6984 (文本电话: 711) 或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય એક્સિબલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

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हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yánilt'i'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jik'eh ná hólq. Bee ahil hane'go bee nida'anishí t'áá ákodaat'éhígíí dóo bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoót'i'ígíí éí t'áá jik'eh hólq. Kohjí' 855-710-6984 (TTY: 711) hodiilnih doodago nika'análwo'í bich'í' hanidziil.
فارسی Farsi	توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به صورت رایگان موجود می باشند. با شماره 855-710-6984 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.
Polски Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 855-710-6984 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY
ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
 - \$300,000 for death benefits
 - \$100,000 for cash surrender or withdrawal values
- Health Insurance
 - \$500,000 for health benefit plans*
 - \$300,000 for disability insurance benefits
 - \$300,000 for long-term care insurance benefits
 - \$100,000 for other types of health insurance benefits
- Annuities
 - \$250,000 for withdrawal and cash values

* The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is \$500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health Insurance
Guaranty Association 901 Warrenville Road, Suite
400
Lisle, Illinois 60532-4324:

Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767:

Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

(Source: Amended at 43 Ill. Reg. 3290, effective February 25, 2019)



**BlueCross BlueShield
of Illinois**



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