BlueCross BlueShield of Illinois

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

# Your Health Care Benefits Program

300 East Randolph Street | Chicago, IL 60601-5099

1-800-541-2767

IL_G_BOP_(H)_OF_2027

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# BENEFIT HIGHLIGHTS

**Plan Name: Blue Options Gold PPO 200SM**

**Network Name: Blue OptionsSM Network**

**IMPORTANT NOTE:** Your benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire Certificate. Unless otherwise stated, all benefits below are subject to your Deductibles and any applicable cost sharing, such as Coinsurance and/or Copayment.

| | |
|---|---|
| **Individual Deductible**<br>**(not all expenses will apply to the Deductible)** | |
| **Blue Options Provider** | $3,800 per Benefit Period |
| **Participating Provider** | $5,200 per Benefit Period |
| **Non-Participating and Non-Plan Provider** | $10,400 per Benefit Period |
| **Family Deductible**<br>**(not all expenses will apply to the Deductible)** | |
| **Blue Options Provider** | $11,400 per Benefit Period |
| **Participating Provider** | $15,750 per Benefit Period |
| **Non-Participating and Non-Plan Provider** | $31,500 per Benefit Period |
| **Individual Out-of-Pocket Expense Limit**<br>**(does not apply to all services)** | |
| **Blue Options Provider** | $3,800 per Benefit Period |
| **Participating Provider** | $7,200 per Benefit Period |
| **Non-Participating and Non-Plan Provider** | Unlimited |
| **Family Out-of-Pocket Expense Limit (does not apply to all services)** | |
| **Blue Options Provider** | $11,400 per Benefit Period |
| **Participating Provider** | $15,750 per Benefit Period |
| **Non-Participating and Non-Plan Provider** | Unlimited |

**COVERAGE DESCRIBED BELOW IS SUBJECT TO THE BENEFIT PERIOD DEDUCTIBLE, COPAYMENTS AND/OR COINSURANCE AMOUNT INDICATED, UNLESS OTHERWISE SPECIFIED.**

**INPATIENT HOSPITAL BENEFITS** – Daily bed, board and general nursing care, ancillary services (i.e., operating rooms, drugs, surgical dressings, and lab work).



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**OUTPATIENT HOSPITAL BENEFITS** – Includes but is not limited to Surgery, Diagnostic Services, radiation therapy, Chemotherapy, electroconvulsive therapy, Renal Dialysis Treatments and continuous ambulatory peritoneal dialysis treatment, Coordinated Home Care program, pre-admission testing, Partial Hospitalization Treatment Program, Autism Spectrum Disorders, Habilitative Services, surgical implants, Maternity Services, abortion care and Urgent Care.

**HOSPITAL BENEFITS**

Payment level for Covered Services from a:

| | |
|---|---|
| **Blue Options Provider** | |
| Inpatient Copayment | $150 per admission |
| Inpatient Covered Services | No Charge, after Deductible |
| Outpatient Surgical Copayment (except for surgical sterilization procedures) | $100 per visit |
| Surgical sterilization procedures | No Charge |
| Outpatient Covered Services | No Charge, after Deductible |
| **Participating Provider** | |
| Inpatient Copayment | $400 per admission |
| Inpatient Covered Services | 20% Coinsurance, after Deductible |
| Outpatient Surgical Copayment (except for surgical sterilization procedures) | $300 per visit |
| Surgical sterilization procedures | No Charge |
| Outpatient Covered Services | 20% Coinsurance, after Deductible |
| **Non-Participating Provider** | |
| Inpatient Covered Services | 40% Coinsurance, after Deductible |
| Outpatient Covered Services | 40% Coinsurance, after Deductible |
| **Non-Plan Provider** | 50% Coinsurance, after Deductible |
| **Hospital Emergency Care** | |
| Payment level for Emergency Accident Care from either a **Participating, Non-Participating or Non-Plan Provider** | No Charge, after Deductible |
| Payment level for Emergency Medical Care (including Mental Illness or Substance Use Disorder services provided in a Hospital emergency department) from either a **Participating, Non-Participating or Non-Plan Provider** | No Charge, after Deductible |



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| | |
|---|---|
| Payment level for Emergency room services that are not Emergency Accident Care, Emergency Medical Care or Mental Illness or Substance Use Disorder services provided in a Hospital emergency department from either a **Participating, Non-Participating or Non-Plan Provider** | No Charge, after Deductible |
| Payment level for Emergency transportation services provided from either a **Participating, Non-Participating or Non-Plan Provider** | , after Deductible |

## OUTPATIENT LABORATORY SERVICES

| **Payment level for Outpatient Laboratory Covered Services** | |
|---|---|
| **Blue Options Provider** | |
| Freestanding Facility | No Charge, after Deductible |
| Hospital | No Charge, after Deductible |
| **Participating Provider** | |
| Freestanding Facility | 20% Coinsurance, after Deductible |
| Hospital | 20% Coinsurance, after Deductible |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |

## OUTPATIENT SURGICAL/MEDICAL SERVICES

| **Payment level for Outpatient Surgical/ Medical Covered Services**<br>**Blue Options Provider** | |
|---|---|
| Freestanding Facility | $100 per visit |
| Hospital | $100 per visit, after Deductible |
| **Participating Provider** | |
| Freestanding Facility | $300 per visit then 20% Coinsurance, after Deductible |
| Hospital | $300 per visit then 20% Coinsurance, after Deductible |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |

## CERTAIN DIAGNOSTIC TESTS

| Payment level for certain diagnostic tests: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI) | |
|---|---|
| **Blue Options Provider** | |
| Freestanding Facility | No Charge, after Deductible |



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| | |
|---|---|
| Hospital | No Charge, after Deductible |
| **Participating Provider** | |
| Freestanding Facility | 20% Coinsurance, after Deductible |
| Hospital | 20% Coinsurance, after Deductible |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |

## OUTPATIENT DIAGNOSTIC X-RAY SERVICES

| Payment level for Outpatient Diagnostic X-Ray Services | |
|---|---|
| **Blue Options Provider** | |
| Freestanding Facility | No Charge, after Deductible |
| Hospital | No Charge, after Deductible |
| **Participating Provider** | |
| Freestanding Facility | 20% Coinsurance, after Deductible |
| Hospital | 20% Coinsurance, after Deductible |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |



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**PHYSICIAN BENEFITS** – Includes but is not limited to Surgery, Anesthesia Services, assistant surgeon, Medical Care, treatment of Mental Illness, or Substance Use Disorders, consultations, mammograms, Outpatient periodic health examinations, routine pediatric care, Diagnostic Services, injected medicines, amino acid-based elemental formulas, electroconvulsive therapy, radiation therapy, Chemotherapy, cancer medications, Outpatient rehabilitative therapy, Autism Spectrum Disorders, Habilitative Services, rehabilitative services, Outpatient respiratory therapy, chiropractic and osteopathic manipulation, hearing screening, diabetes self-management training and education, dental accident care, family planning services, Outpatient contraceptive services, bone mass measurement and osteoporosis, investigational cancer treatment, infertility treatment, pediatric dental services, mastectomy-related services, Maternity Services and abortion care.

## PHYSICIAN BENEFITS

| | |
|---|---|
| Payment level for Surgical/ Medical Covered Services | |
| **Blue Options Provider (except for surgical sterilization procedures)** | No Charge, after Deductible |
| **Participating Provider (except for surgical sterilization procedures)** | 20% Coinsurance, after Deductible |
| **Surgical sterilization procedures** | No Charge |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |
| Payment level for Covered Services received in a Professional Provider's Office | |
| **Blue Options Provider (other than a Specialist)** | No Charge, after Deductible |
| **Participating Provider (other than a Specialist)** | 20% Coinsurance, after Deductible |
| **Blue Options Provider (Specialist)** | No Charge, after Deductible |
| **Participating Provider (Specialist)** | 20% Coinsurance, after Deductible |
| **Chiropractic and Osteopathic Manipulation** | 25 visit maximum per Benefit Period |
| **Naprapathic Services** | 15 visit maximum per Benefit Period |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |

## PHYSICIAN EMERGENCY CARE BENEFITS

| | |
|---|---|
| Payment level for Emergency Accident Care | No Charge, after Deductible |
| Payment level for Emergency Medical Care (including Mental Illness or Substance Use Disorder services provided in a Hospital emergency department) | No Charge, after Deductible |



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| | |
|---|---|
| Payment level for Emergency room services that are not Emergency Accident Care, Emergency Medical Care or Mental Illness or Substance Use Disorder services provided in a Hospital emergency department | No Charge, after Deductible |
| Payment level for Emergency transportation services | , after Deductible |
| Payment level for Outpatient Treatment Of Mental Illness and Substance Use Disorder Rehabilitation Treatment from **a Blue Options Provider** | No Charge, after Deductible |
| Payment level for Outpatient Treatment of Mental Illness and Substance Use Disorder Rehabilitation Treatment from **a Participating Provider** | 20% Coinsurance, after Deductible |



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**PREVENTIVE CARE SERVICES** – Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, Deductible, Copayment or dollar maximum (to be implemented in the quantities and at the times required by applicable law or regulatory guidance): Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and prevention with respect to the individual involved; evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

| Payment level for Preventive Care Services received from a: | |
|---|---|
| **Blue Options Provider** | No Charge |
| **Participating Provider** | No Charge |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |

**OTHER COVERED SERVICES** – Blood and blood components; medical and surgical dressings, supplies, casts and splints, prosthetic devices, orthotic devices, and durable medical equipment.

| Payment Level for **a Blue Options Provider** | No Charge, after Deductible |
|---|---|
| Payment Level for **a Participating Provider** | 20% Coinsurance, after Deductible |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |

**HEARING AID BENEFITS**

| Hearing Aids | |
|---|---|
| Benefit Period | 24 months |
| Benefit maximum | None |
| Benefit payment level | |
| **Blue Options Provider** | No Charge |
| **Participating Provider** | 20% Coinsurance, after Deductible |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |
| Number of Hearing Aids, per ear, each Benefit Period | One |



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## VIRTUAL VISITS

Payment level for Covered Services received through a Virtual Visit

| | |
|---|---|
| **Blue Options Provider** | No Charge, after Deductible |
| **Participating Provider** | 20% Coinsurance, after Deductible |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |

## PEDIATRIC DENTAL CARE SERVICES

| Payment level for Pediatric Dental Services | |
|---|---|
| **Participating Provider** | 30% Coinsurance |
| **Non-Participating Provider** | 50% Coinsurance |

**TO IDENTIFY PARTICIPATING AND NON-PARTICIPATING PHYSICIANS, HOSPITALS, PROVIDERS OR FACILITIES, YOU SHOULD CONTACT BLUE CROSS AND BLUE SHIELD BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD**.

## TELEHEALTH SERVICES

| Payment level for Covered Services received through a Telehealth Visit | |
|---|---|
| **Blue Options Provider** | No Charge, after Deductible |
| **Blue Options Provider (Specialist)** | No Charge, after Deductible |
| **Blue Options Provider for treatment of Mental Illness** | No Charge, after Deductible |
| **Participating Provider** | 20% Coinsurance, after Deductible |
| **Participating Provider (Specialist)** | 20% Coinsurance, after Deductible |
| **Participating Provider for the treatment of Mental Illness** | 20% Coinsurance, after Deductible |
| **Non-Participating Provider** | 40% Coinsurance, after Deductible |
| **Non-Participating Provider (Specialist)** | 40% Coinsurance, after Deductible |
| **Non-Participating Provider for the treatment of Mental Illness** | 40% Coinsurance, after Deductible |



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## 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 Amount and/or Copayment Amount when received from a Participating Prescription Drug Provider. Your share of the cost for all other contraceptive drugs and products will be provided as shown below.

If you or your Provider requests a Brand Name Drug when a Generic Drug or therapeutic equivalent is available, you will be responsible for the Non-Preferred Brand Name Drug payment amount, plus the difference in cost between the Brand Name Drug and the generic or therapeutic equivalent, except as otherwise provided in this Certificate.

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 Pharmacy Provider or Participating Pharmacy Provider.

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

| | |
|---|---|
| Tier 1 | No Charge, after Deductible |
| Tier 2 | No Charge, after Deductible |
| Tier 3 | No Charge, after Deductible |
| Tier 4 | No Charge, after Deductible |

**Participating Copayment and/or Coinsurance for covered drugs and supplies**

**Payment level for drugs and supplies**

| | |
|---|---|
| Tier 1 | No Charge, after Deductible |
| Tier 2 | No Charge, after Deductible |
| Tier 3 | No Charge, after Deductible |
| Tier 4 | No Charge, after Deductible |



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**Specialty and Complex Care Prescription Drug Program**

"Coverage for Specialty and Complex Care Drugs are limited to a 30-day supply. However, some Specialty and Complex Care Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply, if allowed by your plan benefits. Cost-share will be based on the day supply dispensed. (1-30 day supply; 31-60 day supply; 61-90 day supply)."

| | |
|---|---|
| Tier 5 | No Charge, after Deductible |
| Tier 6 | No Charge, after Deductible |

**Home Delivery Copayment and/or Coinsurance for covered drugs and supplies**

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

| | |
|---|---|
| Tier 1 | No Charge, after Deductible |
| Tier 2 | No Charge, after Deductible |
| Tier 3 | No Charge, after Deductible |
| Tier 4 | No Charge, after Deductible |

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

Select Covered Drugs determined by the Plan, may be covered with no cost share, to make these medications more affordable to members, Deductible applies.

**NON-PARTICIPATING PHARMACY PROVIDER — OUTPATIENT PRESCRIPTION DRUG PROGRAM**

*When you obtain Covered Drugs, including diabetic supplies from a Non-Participating Pharmacy Provider or a non-Preferred Specialty Pharmacy Provider (other than a Participating Pharmacy Provider), benefits will be provided at 50% of the amount you would have received had you obtained drugs from a Participating Pharmacy Provider minus the Deductible, if any. If an out-of-pocket expense limit is shown above for Non-Participating Providers, then only your Deductible, if any, Copayment Amount and Coinsurance Amount will apply towards the above out-of-pocket expense limit for Non-Participating Providers. However, none of your other expenses at such Non-Participating Pharmacy Provider will apply towards the out-of-pocket expense limit.

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



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## Schedule of Pediatric Vision Care Coverage

## For Covered Persons Under Age 19

| **Pediatric Vision Care Services** | **Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider** (When a fixed-dollar Copayment is due from the Covered Person, the remainder is payable under the Certificate up to the covered charge*) | **Allowance when Covered Services are received from a Non-Participating Vision Provider** (Maximum amount payable by plan under the Certificate, not to exceed the retail costs)** |
|---|---|---|
| **Exam** (with dilation as necessary; routine eye examinations do not include professional services for contact lenses): | No Copayment | $30 |
| **Frames:** | | |
| "Provider-Designated" frame<br>Frames covered by this Certificate are limited to the provider-designated frames which include a selection of frame sizes (including adult sizes) for children up to age 19. The Participating Vision Provider will show you the selection of frames covered by this Certificate. | No Copayment, after deductible | $75, after deductible |
| **Frequency:**<br>Examination, Lenses, or Contact Lenses | Once every 12-month Benefit Period | |
| **Frame** | Once every 12-month Benefit Period | |
| **Standards Plastic, Glass, or Polycarbonate Spectacle Lenses:** | | |
| Single Vision | No Copayment, after deductible | $25, after deductible |
| Bifocal | No Copayment, after deductible | $40, after deductible |
| Trifocal | No Copayment, after deductible | $55, after deductible |
| Lenticular | No Copayment, after deductible | $55, after deductible |
| Standard Progressive Lens | No Copayment, after deductible | $55, after deductible |
| **Lens Options (add to lens costs above):** | | |
| UV Treatment | No Copayment, after deductible | $12, after deductible |
| Tint (Fashion & Gradient & Glass-Grey) | No Copayment, after deductible | $12, after deductible |
| Standard Plastic Scratch Coating | No Copayment, after deductible | $12, after deductible |



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| | | |
|---|---|---|
| Standard Polycarbonate | No Copayment, after deductible | $32, after deductible |
| Standard Polycarbonate – Kids under 19 | No Copayment, after deductible | $32, after deductible |
| Glass | No Copayment, after deductible | $12, after deductible |
| Photochromatic / Transitions Plastic | No Copayment, after deductible | $57, after deductible |
| Oversized | No Copayment, after deductible | N/A |
| **Contact Lenses:** (Contact lens allowance includes materials only) | 100% coverage for provider-designated contact lenses, after deductible | |
| Elective- Extended Wear Disposables | Up to 6 months' supply of monthly or 2-week disposable, single vision spherical or toric contact lenses, after deductible | $150, after deductible |
| Daily Wear / Disposable | Up to 3 months' supply of daily disposable, single vision spherical contact lenses, after Deductible | $150, after deductible |
| Conventional | 1 pair from selection of provider-designated contact lenses, after Deductible | $150, after deductible |
| Medically Necessary contact lenses – Preauthorization is required (see details below) | No Copayment, Paid-in-Full, after deductible | $210, after deductible |
| Contact lenses covered under the Certificate are limited to the provider-designated contact lenses. The Participating Vision Provider will inform you of the contact lens selection covered under the Certificate. | | |
| Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient. | | |
| **Value-added features:**<br><br>**Laser vision correction:** You will receive a discount for traditional LASIK and custom LASIK from Participating Physicians and affiliated laser centers. You must obtain Preauthorization for this service in order to receive coverage. Prices/discounts may vary by state and are subject to change without notice. | | |
| **Additional Benefits** | | |
| **Medically Necessary contact lenses**: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:<br><br>keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism. | | |



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|---|
| Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating providers will obtain the necessary preauthorization for these services. |
| **Low Vision:** Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for our members with low vision.<br><br>With prior approval from Blue Cross and Blue Shield of Illinois, covered persons who required low-vision services and optical devices are entitled to the following coverage, with both Participating and Non-Participating Providers:<br><br>**Low Vision Evaluation:** One comprehensive evaluation every five years (Non-Participating Allowance of $300). This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.<br><br>**Low Vision Aid:** Covered for one device per year such as high-power spectacles, magnifiers and telescopes Non-Participating Allowance of $600 per device and $1200 lifetime). These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's vision goals and lifestyle needs.<br><br>**Follow-up care:** Four visits in any five-year period (Non-Participating Allowance of $100 per visit). |
| **Warranty:** Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Please ask your Provider for details of the warranty that is available to you. |

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

** Member reimbursement for a non-participating provider will be the lesser of the listed amount of the member's actual cost from the non-participating provider.

**YOU WILL BE RESPONSIBLE FOR SUBMITTING A CLAIM FOR REIMBURSEMENT WHEN RECEIVING SERVICES FROM A NON-PARTICIPATING PROVIDER.**

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



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A message from

## BLUE CROSS AND BLUE SHIELD

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 will provide the health care benefits described in this benefit program. Like most people, you probably have many questions about your coverage. This Certificate contains a great deal of information about the services and supplies for which benefits will be provided under your benefit program. Please read your entire Certificate very carefully. We hope that most of the questions you have about your coverage will be answered.

In this Certificate we refer to our company as “Blue Cross and Blue Shield”, “BCBSIL”, and/or “Blue Cross and Blue Shield of Illinois”, and we refer to the company that you work for as the “Group.” Any references to “applicable law” will include applicable laws and rules, including but not limited to statutes, ordinances, administrative decisions, and regulations. 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.

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

THIS CERTIFICATE REPLACES ANY PREVIOUS CERTIFICATES THAT MAY HAVE BEEN ISSUED TO YOU BY BLUE CROSS AND BLUE SHIELD.

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

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

Sincerely,

Brian Snell

President,

Blue Cross Blue Shield of Illinois



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## NOTICE

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

**Please refer to the provision titled "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.**

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

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

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

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

**NOTICE:** Certain individuals who receive cost-sharing reductions under this benefit plan, that have the effect of reducing the deductible below the federal government's minimum deductible, may not be eligible to contribute to a Health Savings Account. Please consult your tax advisor for further information.


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## DEFINITIONS SECTION

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

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

**ACUPUNCTURISTS** – means a duly licensed acupuncturist operating within the scope of their license.

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

**ADVANCED PRACTICE NURSE** – means a Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist, operating within the scope of their applicable license and/or certification.

**AMBULANCE TRANSPORTATION** – means a Medically Necessary local transportation service in a specially equipped certified vehicle for ground and air transportation options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. Such benefits also include Medically Necessary non-transportation services (such as evaluation/treatment without transport or paramedic intercept) that is provided in a ground ambulance licensed under the Emergency Medical Services (EMS) Systems Act or by personnel assigned to a ground ambulance licensed under the Emergency Medical Services (EMS) Systems Act. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means a transportation service to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this Certificate.

**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.

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

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

1. A federally funded or approved trial.
2. A clinical trial conducted under an FDA Experimental/Investigational new drug application, or
3. A drug that is exempt from the requirement of an FDA Experimental/Investigational new drug application.

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

**AVERAGE DISCOUNT PERCENTAGE ("ADP")** – means a percentage discount calculated by Blue Cross and Blue Shield that will be applied to a Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, Deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, which is relevant to the particular Claim. The ADP reflects Blue Cross and Blue Shield's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this Certificate regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, Blue Cross and Blue Shield will take into account differences among Hospitals and


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other facilities, Blue Cross and Blue Shield's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under this Certificate are secondary to Medicare and/or coverage under any other group program.

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

**BEHAVIORAL HEALTH PRACTITIONER** – means a Physician or Professional Provider who is duly licensed to render Covered Services for Mental Illness or Substance Use Disorder and is operating within the scope of such license.

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

**BENEFIT PERIOD** – means the period beginning on the Coverage Date and ending on the termination date, except for the Pediatric Vision Care Benefit Period, which is defined in the **PEDIATRIC VISION CARE** section of this Certificate.

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

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

**BLUE CROSS AND BLUE SHIELD** – means Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

**BLUE OPTIONS PPO℠ PROVIDER** – See definition of Provider.

**BLUE OPTIONS PROVIDER** – means a Provider which has a written agreement with Blue Cross and Blue Shield of Illinois to provide Covered Services to participants in a Blue options PPO℠ benefit program or another Blue Cross and/or Blue Shield Plan which has a written agreement to provide Covered Services to participants.

**CARE COORDINATION** – means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's healthcare needs cross the continuum of care.

**CARE COORDINATOR FEE** – means a fixed amount paid by a Blue Cross and/or Blue Shield Plan to Providers periodically for Care Coordination under a Value-Based Program.

**CERTIFICATE** – means this booklet, including your application(s) for coverage under the Blue Cross and Blue Shield benefit program described in this booklet.

**CERTIFICATE OF CREDITABLE COVERAGE** – means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program.

**CERTIFIED CLINICAL NURSE SPECIALIST** – means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

1. Is a graduate of an approved school of nursing and holds a current license as a registered nurse, and is operating within the scope of such license; and
2. Is a graduate of an advanced practice nursing program.

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

**CERTIFIED NURSE-MIDWIFE** – means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

1. Is a graduate of an approved school of nursing and holds a current license as a registered nurse, and is operating within the scope of such license; and
2. Is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

**CERTIFIED NURSE PRACTITIONER** – means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

1. Is a graduate of an approved school of nursing and holds a current license as a registered nurse, and is operating within the scope of such license; and
2. Is a graduate of an advanced practice nursing program.

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

**CHIROPRACTOR** – means a duly licensed Chiropractor operating within the scope of their license.

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

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

**CLAIM** – means notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which Blue Cross and Blue Shield may request in connection with Covered Services rendered to you.

**CLAIM CHARGE** – means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Certificate regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers").

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

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

**CLINICAL PSYCHOLOGIST** – means a psychologist who specializes in the evaluation and treatment of Mental Illness or 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 post-doctoral and one year is in an organized health services program; or
2. Is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

**CLINICAL SOCIAL WORKER** – means a duly licensed Clinical Social Worker operating within the scope of their license.

**CLINICAL STABILIZATION SERVICES** – means 24-hour treatment, usually following acute treatment services for Substance Use Disorder, which may include intensive education and counseling regarding the nature of addiction and its


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consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

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

**COBRA** – means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

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

**COMPLEX REHABILITATION TECHNOLOGY** - means a Medically Necessary complex wheelchair and associated accessories that is individually configured for an individual to meet specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living.

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

**CONGENITAL OR GENETIC DISORDER** – means a disorder that includes, but is not limited to: hereditary disorders, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

**COORDINATED HOME CARE PROGRAM** – means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the Covered 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.).

**COPAYMENT** – means a specified dollar amount 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, professional training, and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

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

**DENTIST** – means a duly licensed Dentist operating within the scope of their license.

**DEPENDENT** – means an Eligible Person's spouse, party to a Civil Union, Domestic Partner, parent or stepparent, or any child(ren) covered under this Certificate.

**DIAGNOSTIC SERVICE** – means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, Clinical Laboratory tests, pulmonary function studies, peripheral artery disease screening, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT scans) and positron emission tomography (PET scans).

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

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


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

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

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

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

**ELIGIBLE CHARGE** – means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to participants in the PPO benefit program, or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan, at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services, and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to participants in the PPO benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan, at the time Covered Services are rendered, of the following amount:

1. The lesser of (unless otherwise required by applicable law or arrangement with the Non- Participating Provider) (a) the Provider's Billed Charges, and (b) an amount determined by Blue Cross and Blue Shield of Illinois to be approximately 105% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or
2. If there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (1) above based upon the information submitted on the Claim, the lesser of(unless otherwise required by applicable law or arrangement with the Non-Participating Provider)(a) the Provider's Billed Charges and (b) an amount determined by Blue Cross and Blue Shield of Illinois to be 150% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or
3. If the base Medicare reimbursement amount and the Maximum Allowance cannot be determined under subsections (1) or (2) above, based upon the information submitted on the Claim, then the amount will be 50% of the Provider's Billed Charges, provided, however, that Blue Cross and Blue Shield may limit such amount to the lowest contracted rate that Blue Cross and Blue Shield has with a Participating Provider for the same or similar service based upon the type of Provider and the information submitted on the claim, as of January 1 of the same year that the Covered Services are rendered to the member (unless otherwise required by applicable law or arrangement with the Non-Participating Providers).

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

**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 ACCIDENT CARE** – means the initial Outpatient treatment of accidental injuries including related Diagnostic Service.


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

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

1. Placing the health of the individual (or, with respect to a pregnant individual, the health of the mother/birthing parent or their unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.
4. Inadequately controlled pain; or
5. With respect to a pregnant individual who is having contractions:
    a. Inadequate time to complete a safe transfer to another hospital before delivery; or
    b. A transfer to another hospital may pose a threat to the health or safety of the mother/birthing parent or unborn child.

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

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

**ENROLLMENT DATE** – means the first day of coverage under your Group's health plan or, if your Group has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins). No such waiting period may exceed 90 days unless permitted by applicable law. If our records show that your Group has a waiting period that exceeds the time period permitted by applicable law, then we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your Group is responsible for your waiting period. If you have questions about your waiting period, please contact your Group.

**EXPERIMENTAL/INVESTIGATIONAL SERVICES AND SUPPLIES** – means the use of any treatment, procedure, facility, equipment, drug, device, or supply (including emerging technologies, services, procedures, and service paradigms) not accepted as Standard Medical Treatment for the condition being treated or, if any of such items required Federal or other governmental agency approval, such approval was not granted at the time services were provided. Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.
As used herein, medical treatment includes medical, surgical, mental health treatment, Substance Use Disorder Treatment or dental treatment.

**FAMILY COVERAGE** – means coverage for you and your eligible spouse and/or dependents under this Certificate.

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

**GROUP POLICY or POLICY** – means the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, the Group's application, and the Plan, as appropriate, along with any exhibits, appendices, addenda and/or other required information and the individual application(s) of the persons covered under the benefit program.

**HABILITATIVE SERVICES** – means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a treatment plan 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


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pathology, and other services for a Covered Person with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in the Certificate.

**HIGH-DEDUCTIBLE HEALTH PLAN - HEALTH SAVINGS ACCOUNT (HDHP-HSA)** – means a health insurance plan which combines a High-Deductible Health Plan (HDHP) with a Health Savings Account (HSA).

**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.

**HIPPOTHERAPY -** means the use of equine movement by a licensed occupational therapist, a licensed physical therapist, or a speech-language pathologist, in conjunction with a professional horse handler and a therapy horse, to engage sensory, neuromotor, and cognitive systems to promote functional outcomes.

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

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

**HOSPICE CARE PROGRAM SERVICE** – means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility, or special hospice care unit.

**HOSPITAL** – means a duly licensed institution under state law for the care of the sick which provides Covered Services under the care of a Physician including the regular provision of bedside nursing by registered nurses, irrespective of whether the institution provides surgery on its premises or at another licensed hospital pursuant to a formal written agreement between the two institutions. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, or custodial homes of the aged or similar institutions.

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

**INDIVIDUAL COVERAGE** – means coverage under this Certificate for yourself but not your spouse and/or dependents.

**INFERTILITY** – means a disease, condition, or status characterized by:

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

**INFUSION THERAPY** – means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively through oral medications. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term refers to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

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

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


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**INTENSIVE OUTPATIENT PROGRAM** – means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder. Requirements: 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 Blue Cross and Blue Shield as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

**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 condition will occur.

**MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY** - means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

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

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

**MAXIMUM ALLOWANCE** – means (a) the amount which Participating Professional Providers have agreed to accept as payment in full, or the amount of reimbursement amount set by the Plan for Providers designated as Participating Professional Providers, for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers, will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with the Non- Participating Provider):

1. The Provider's Billed Charges, or.
2. Blue Cross and Blue Shield of Illinois non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 105% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

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

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 100% of Blue Cross and Blue Shield of Illinois' rate for such Covered Service according to its current Schedule of Maximum Allowance (unless otherwise required by applicable law or arrangement with the Non-Participating Provider). If there is no rate according to the Schedule of Maximum Allowance, then the Maximum Allowance will be 25% of Billed Charges (unless otherwise required by applicable law or arrangement with the Non-Participating Provider).

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


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

PLEASE REFER TO THE SECTION TITLED “Exclusions – What Is Not Covered” for additional information.

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

**MEDICARE SECONDARY PAYER or MSP** – means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare- eligible employees, their spouses and, in some cases, Dependent children.

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

**NAPRAPATH** – means a duly licensed Naprapath operating within the scope of their license.

**NAPRAPATHIC SERVICES** – means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

**NAPRAPATHY** – Naprapathy means the identification, evaluation, and treatment of those with connective tissue disorders by the use of connective tissue manipulation, therapeutic and rehabilitative exercise, postural counseling, nutritional counseling, and the use of the effective properties of physical measures and assistive devices for the purpose of preventing, correcting, or alleviating a physical disability.

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

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

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

**NON-PARTICIPATING CERTIFIED NURSE-MIDWIFE** – means a Certified Nurse-Midwife who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**NON-PARTICIPATING CERTIFIED CLINICAL NURSE SPECIALIST** – means a Certified Clinical Nurse Specialist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to you at the time Covered Services are rendered.

**NON-PARTICIPATING CERTIFIED REGISTERED NURSE ANESTHETIST** – means a Certified Registered Nurse Anesthetist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**NON-PARTICIPATING CERTIFIED NURSE PRACTITIONER** – means a Certified Nurse Practitioner who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in program at the time Covered Services are rendered.

**NON-PARTICIPATING CLINICAL LABORATORY** – means a Clinical Laboratory which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit the time Covered Services are rendered.


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**NON-PARTICIPATING CLINICAL PROFESSIONAL COUNSELOR** – means a Clinical Professional Counselor who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**NON-PARTICIPATING CLINICAL SOCIAL WORKER** – means a Clinical Social Worker who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

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

**NON-PARTICIPATING DURABLE MEDICAL EQUIPMENT PROVIDER** – means a Durable Medical Equipment Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**NON-PARTICIPATING HOME INFUSION THERAPY PROVIDER** – means a Home Infusion Therapy Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**NON-PARTICIPATING HOSPICE CARE PROGRAM PROVIDER** – means a Hospice Care Program Provider that either: (i) does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in this benefit program or; ii) a Hospice Care Program Provider that has not been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider in the benefit program.

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

**NON-PARTICIPATING MARRIAGE AND FAMILY THERAPIST** – means a Marriage and Family Therapist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**NON-PARTICIPATING SKILLED NURSING FACILITY** – means a Skilled Nursing Facility which does not have an agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan at the time Covered Services are rendered but has been certified in accordance with guidelines established by Medicare.

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

**NON-PARTICIPATING PROFESSIONAL PROVIDER** – means a Professional Provider who does not have a written agreement with a Blue Cross and Blue Shield plan to provide Covered Services to participants in the benefit program. For purposes of the provision of this Certificate titled "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED," a Non-Participating Provider includes, but is not limited to, a Non-Participating Professional Provider.

**NON-PARTICIPATING PROVIDER** – means a Plan Hospital or Professional Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program or a facility which has not been designated by Blue Cross and Blue Shield of Illinois as a Participating Provider at the time Covered Services are rendered.

**NON-PARTICIPATING RETAIL HEALTH CLINIC** – means a Retail Health Clinic who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**NON-PARTICIPATING OPTOMETRIST** – means an Optometrist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**NON-PARTICIPATING ORTHOTIC PROVIDER** – means an Orthotic Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER or NON PARTICIPATING PHARMACY PROVIDER** – means a Pharmacy, including but not limited to, an independent retail Pharmacy, chain of retail Pharmacies, home


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delivery Pharmacy, or specialty drug Pharmacy Provider which has not entered into a written agreement with any entity chosen by Blue Cross and Blue Shield to administer its prescription drug program for such Pharmacy to provide pharmaceutical services at the time Covered Services are rendered to participants in the benefit program.

**NON-PARTICIPATING PROSTHETIC PROVIDER** – means a Prosthetic Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**NON-PARTICIPATING REGISTERED SURGICAL ASSISTANT** – means a registered surgical assistant who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

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

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

**NON-PLAN HOSPITAL** - means a Hospital that does not meet the definition of a Plan Hospital.

**NON-PLAN PROVIDER** – means a Provider that does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

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

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

**ONGOING COURSE OF TREATMENT** – means has the meaning set forth in the provision titled, “CONTINUITY OF CARE.”

**OPHTHALMOLOGIST** – means a duly licensed Ophthalmologist operating within the scope of their license.

**OPTOMETRIST** – means a duly licensed Optometrist operating within the scope of their license.

**ORTHOTIC PROVIDER** – means a duly licensed orthotic Provider operating within the scope of their license.

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

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

**PARTICIPATING CERTIFIED CLINICAL NURSE SPECIALIST** – means a Certified Clinical Nurse Specialist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

**PARTICIPATING CERTIFIED NURSE-MIDWIFE** – means a Certified Nurse-Midwife who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.


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**PARTICIPATING CERTIFIED NURSE PRACTITIONER** – means a Certified Nurse Practitioner who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**PARTICIPATING CERTIFIED REGISTERED NURSE ANESTHETIST** – means a Certified Registered Nurse Anesthetist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any BlueCross and Blue Shield Plan at the time Covered Services are rendered.

**PARTICIPATING CLINICAL LABORATORY** – means a Clinical Laboratory which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**PARTICIPATING CLINICAL PROFESSIONAL COUNSELOR** – means a Clinical Professional Counselor who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

**PARTICIPATING CLINICAL SOCIAL WORKER** – means a Clinical Social Worker who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

**PARTICIPATING COORDINATED HOME CARE PROGRAM** – means a Coordinated Home Care Program which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**PARTICIPATING DURABLE MEDICAL EQUIPMENT PROVIDER** – means a Durable Medical Equipment Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**PARTICIPATING HOME INFUSION THERAPY PROVIDER** – means a Home Infusion Therapy Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**PARTICIPATING HOSPICE CARE PROGRAM PROVIDER** – means a Hospice Care Program Provider that either: (i) has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program, or; (ii) a Hospice Care Program Provider that has been designated by any Blue Cross and/or Blue Shield Plan as a Participating Provider in the benefit program.

**PARTICIPATING HOSPITAL** – means a Plan Hospital that has an agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Hospital Covered Services to participants in the benefit program at the time Hospital services are rendered.

**PARTICIPATING HOSPITAL** – SEE DEFINITION OF HOSPITAL.

**PARTICIPATING PROVIDER** – SEE DEFINITION OF PROVIDER.

**PARTICIPATING MARRIAGE AND FAMILY THERAPIST** – means a Marriage and Family Therapist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**PARTICIPATING OPTOMETRIST** – means an Optometrist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

**PARTICIPATING ORTHOTIC PROVIDER** – means an Orthotic Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**PARTICIPATING SKILLED NURSING FACILITY** – means a Skilled Nursing Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan to provide Covered Services to participants

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

**PARTICIPATING PROFESSIONAL PROVIDER** – SEE DEFINITION OF PROVIDER.

**PARTICIPATING PROSTHETIC PROVIDER** – means a Prosthetic Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

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

**PARTICIPATING RETAIL HEALTH CLINIC** – means a Retail Health Clinic who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan.

**PARTICIPATING SUBSTANCE USE DISORDER TREATMENT FACILITY -** means a Substance Use Disorder Treatment Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and Blue Shield plan at the time Covered Services are rendered.

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

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

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

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

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

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

**PLAN AMBULATORY SURGICAL FACILITY** – means an Ambulatory Surgical Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

**PLAN COORDINATED HOME CARE PROGRAM** – means a Coordinated Home Care Program which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and Blue Shield Plan at the time Covered Services are rendered.

FOR ADDITIONAL INFORMATION ABOUT HOW YOUR SHARE OF COSTS IS CALCULATED, REFER TO THE SECTION TITLED" Blue Cross and Blue Shield's Separate Financial Arrangements with Providers".

1. Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated.


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2. Are appropriate for the Hospital or other Facility Provider in which the treatment or procedure were performed; and

3. The Physician or other Professional Provider has had the appropriate training and experience to provide the treatment or procedure.

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

**PLAN HOSPITAL** – means a Hospital which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**PLAN PROVIDER** – means a Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered to you.

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

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

**PRIOR AUTHORIZATION** – means a requirement that you must obtain authorization from Blue Cross and Blue Shield before you receive certain types of Covered Services designated by Blue Cross and Blue Shield.

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

**PROFESSIONAL PROVIDER** – SEE DEFINITION OF PROVIDER.

**PROSTHETIC PROVIDER** - means a duly licensed prosthetic Provider operating within the scope of their license.

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

**PARTICIPATING PROVIDER** – means a Plan Hospital or Professional Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in benefit program or a Plan facility or Professional Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider.

**PROFESSIONAL PROVIDER** – means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider designated by Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

**PARTICIPATING PROFESSIONAL PROVIDER** – means a Professional Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in benefit program at the time Covered Services are rendered or a Professional Provider who has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Professional Provider.

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

**PARTICIPATING REGISTERED SURGICAL ASSISTANT** – means a registered surgical assistant who is classified as having a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.


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

**PSYCHOLOGIST** – means a Registered Clinical Psychologist operating within the scope of their license.

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

For the treatment supervisor / case manager / facilitator:

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

For the para-professional / line therapist:

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

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

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

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

**REHABILITATIVE SERVICES** – means including, but not limited to, Speech Therapy, Physical Therapy and Occupational Therapy. Treatment, as determined by your Physician, that must be either (a) limited to therapy which is expected to result in significant improvement in the condition for which it is rendered, except as specifically provided for under the Autism Spectrum Disorder(s) provision and the plan must be established before 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. "Rehabilitative Services" must be expected to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury or disabling condition.

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


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

**RESIDENTIAL TREATMENT CENTER** – means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure medically necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

**RESPITE CARE SERVICE** – means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services for you.

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

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

Routine Patient Costs do not include:

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

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

**SKILLED NURSING SERVICE** – means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

**SMALL EMPLOYER** (Employer) – means a person (individual, corporation, partnership, or other legal entity) who employed an average of at least two employees but not more than 50 Eligible Persons on business days during the preceding Calendar Year and who employs at least two employees on the first day of the plan year.

**SPEECH THERAPIST** – means a duly licensed Speech Therapist operating within the scope of their license.

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

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


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

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

**SUBSTANCE USE DISORDER TREATMENT FACILITY** – means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such license. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

**STANDARD MEDICAL TREATMENT** – means the services or supplies that are in general use in the medical community in the United States, and:

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

Although a Physician or Professional Provider may have prescribed treatment, and the Covered Services or supplies may have been provided as the treatment of last resort, such Covered Services or supplies may still be considered to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial, or a research study is Experimental/Investigational.

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

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

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

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

**THERAPY** – means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

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

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


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4. With the presence of signs or symptoms compatible with acute infection of borrelia or other Tick-Borne Diseases.

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

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

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

**UNCERTIFIED SKILLED NURSING FACILITY** – means a Skilled Nursing Facility which does not meet the definition of a Plan Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

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

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

**VIRTUAL VISIT** – means a service Provided for the diagnosis or treatment of Non-Emergency medical and/or behavioral health illnesses or injuries as described in the Virtual Visits provision under the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

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


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## ELIGIBILITY

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

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

**Replacement of Discontinued Group Coverage**

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

Your Totally Disabled dependents will be considered eligible dependents under this Certificate if such dependents meet the description of an eligible family member as specified in the Eligibility Section of this Certificate.

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

If you are Totally Disabled, you will be entitled to all of the benefits described in this Certificate. The benefits of this Certificate will be coordinated with the benefits under your prior group policy. Your prior group policy will be considered the primary coverage for all services rendered in connection with your disabling condition when no coverage is available under this Certificate due to the absence of coverage in this Certificate.

**APPLYING FOR COVERAGE**

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

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

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

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


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A Tobacco User may be subject to a premium of up to 1.5 times the rate applicable to those who are not Tobacco Users, to the extent permitted by applicable law or regulatory guidance, provided that Blue Cross and Blue Shield will provide an opportunity to offset such premium variation through participation in a wellness program to prevent or reduce Tobacco Use, if required by applicable law.

You may enroll in or change coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents during one of the following enrollment periods. You and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' effective date will be determined by the Blue Cross and Blue Shield, depending upon the date your application is received and other determining factors.

Blue Cross and Blue Shield may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an Eligible Person and/or family member under this Certificate.

**Annual Open Enrollment Periods/Effective Date of Coverage**

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

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

**SPECIAL ENROLLMENT PERIODS**

**Special Enrollment Periods/Effective Dates of Coverage**

Special Enrollment Periods have been designated during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents. You must apply for or request a change in coverage within 30 days from the date of a special enrollment event, except as otherwise provided below, in order to qualify for the changes described in this Special Enrollment Periods/Effective Dates of Coverage provision. Except as otherwise provided below, your effective date will be no later than the 1st day of the following month.

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

**Special Enrollment Events**:

1. You gain or lose a Dependent or become a Dependent through marriage, becoming a party to a Civil Union or establishment of a Domestic Partnership, provided your employer covers Domestic Partners. New coverage for you and/or your eligible spouse, party to a Civil Union or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective no later than the first day of the following month.
2. You gain or lose a Dependent through birth, adoption, or placement of a foster child or for adoption or court-ordered Dependent coverage. New coverage for you and/or your eligible spouse, party to a Civil Union or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective on the date of the birth, adoption, or placement of a foster child or for adoption. However, the effective date for court-ordered eligible child coverage will be determined by the provisions of the court order.
3. You lose eligibility for coverage under a Medicaid plan or a state child health plan under title XXI of the Social Security Act. You must request coverage within 60 days of loss of coverage.
4. You become eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or state child health plan. You must request coverage within 60 days of such eligibility.

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

**Other Special Enrollment Events/Effective Dates of Coverage**


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You must apply for or request a change in coverage within 30 days from the date of the below other special enrollment events in order to qualify for the changes described in this Other Special Enrollment Events/Effective Dates of Coverage provision.

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

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

This provision "SPECIAL ENROLLMENT PERIODS" is subject to change by Blue Cross and Blue Shield and/or applicable law or regulatory guidance, as appropriate.

**NOTIFICATION OF ELIGIBILITY CHANGES**

It is the Eligible Person's responsibility to notify Blue Cross and Blue Shield of any change to an Eligible Person's name or address or other changes to eligibility. Such changes may result in coverage/benefit changes for you and your eligible family members. For example, if you move out of Blue Cross and Blue Shield's "network service area". You must reside or live or work in the geographic "network service area" designated by Blue Cross and Blue Shield. You may call customer service at the number shown on your identification card to determine if you live in the network service area or log on to the website at www.bcbsil.com.

**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, party to a Civil Union, Domestic Partner and your (and/or your spouse, party to a Civil Union, Domestic Partner's) enrolled children who are under the limiting age specified below will be covered.

All the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union. A Domestic Partner and their children who have not attained the limiting age specified below may also be eligible dependents, provided your


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employer covers Domestic Partners. All the provisions of this Certificate that pertain to a spouse may also apply to a Domestic Partner, provided your employer covers Domestic Partners.

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

1. Live within the network service area for this Certificate; and
2. Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
3. Have received a release or discharge other than a dishonorable discharge.

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

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

Coverage for such a Dependent may be continued under the Certificate until the date that is the earlier of:

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

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

Coverage for 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. Please notify Blue Cross and Blue Shield within 31 days of the birth so that your membership records can be adjusted. Your Group Administrator can tell you how to submit the proper notice through Blue Cross and Blue Shield.

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

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

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

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


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

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

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

**NOTE:** If you are an employee of the Group who meets the eligibility requirements for benefits under this Certificate, your Dependent parents or stepparents may also be eligible for coverage when they live or reside within the Network Service Area for this Certificate.

**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. References to spouse under this section do not include a party to a Civil Union with the Eligible Person, the Domestic Partner (provided your employer covers Domestic Partners) of the Eligible Person or their children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the GHP.

In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."
2. In the case of individuals aged 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status".

If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

**Please 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 Blue Cross and Blue Shield 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 ID card from Blue Cross and Blue Shield. Your identification card contains your identification number. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, contact customer service, or go to www.bcbsil.com and get a temporary card online. Always carry your ID card with you.

**LATE APPLICANTS**


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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.

**TERMINATION OF COVERAGE**

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

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

1. The termination date specified by you if you provide reasonable notice.
2. When Blue Cross and Blue Shield does not receive the full amount of the premium payment or other charge or amount on time or when there is a bank draft failure of premiums for your and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' coverage and the grace period, if any, has been exhausted.
3. You no longer live, reside, or work in Blue Cross and Blue Shield's service area or and live, work, reside in a network service area.
4. Your coverage has been rescinded. See the definition of "Rescission" for additional information in the **DEFINITIONS SECTION** of this Certificate.

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

**Termination of a Dependent's Coverage**

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

**WHO IS NOT ELIGIBLE**

The following individuals are not eligible for this coverage:

1. Incarcerated individuals, other than incarcerated individuals pending disposition of charges.
2. Individuals that do not live, reside, or work in the network service area; and
3. Individuals that do not meet Blue Cross and Blue Shield's eligibility requirements or residency standards, as appropriate.

This provision "**WHO IS NOT ELIGIBLE**" is subject to change by Blue Cross and Blue Shield and/or applicable law or regulatory guidance, as appropriate.

**Extension of Benefits in Case of Discontinuance of Coverage**

If you are Totally Disabled at the time your entire Group terminates, benefits will be provided for (and limited to) the Covered Services described in this Certificate which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's policy due to the absence of coverage in the policy. Benefits will be provided for a period of no more than 12 months from the date of termination. It is your responsibility to notify Blue Cross and Blue Shield, and to provide, when requested by Blue Cross and Blue Shield, written documentation of your disability. This extension of benefits does not apply to the Outpatient Prescription Drug Program Benefit Section.


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# UTILIZATION MANAGEMENT

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on BCBSIL Medical Policy and/or level of care review criteria, Medically Necessary reviews may occur prior to services rendered, during the course of care, or after care has been completed.

## PRIOR AUTHORIZATION

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

## PRIOR AUTHORIZATION RESPONSIBILITY

### Participating Provider Prior Authorization

Your Participating Provider is responsible for obtaining Prior Authorization, in those circumstances where authorization may be required. If Prior Authorization is not obtained and the services are denied as not Medically Necessary, the Participating Provider will be held responsible and will not be able to bill the Member for the services.

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

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

### Non-Participating Provider Prior Authorization

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

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

To determine if a specific service or category requires Prior Authorization, visit our website at https://www.bcbsil.com/find-care/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card to determine if Prior Authorization is required and/or to request a Prior Authorization.

### Inpatient Admissions

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


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

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

Participating Provider Benefits will be available if you use a Participating Plan Provider or Participating Specialty Care Provider. If you elect to use Non-Participating Providers for services and supplies available from Participating Providers, Non-Participating Plan Benefits will be paid.

However, if care is not reasonably available from Participating Providers as defined by applicable law, and BCBSIL authorizes your visit to a Non-Participating Provider to be covered at the Participating Plan Benefit level **prior to the visit**, Participating Plan Benefits will be paid; otherwise, Non-Participating Plan Benefits will be paid.

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

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

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

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

**1.** Maternity Care:

   a. 48 hours following an uncomplicated vaginal delivery.

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

**2.** Treatment of Breast Cancer:

   a. 48 hours following a mastectomy.

   b. 24 hours following a lymph node dissection.

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

You or your Provider will not be required to obtain Prior Authorization from BCBSIL for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer


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stay, you, your authorized representative, or your Provider must seek an extension for the additional days by obtaining Prior Authorization from BCBSIL.

**FAILURE TO NOTIFY FOR INPATIENT SERVICES**

The final decision regarding your course of treatment is solely your responsibility and Blue Cross and Blue Shield will not interfere with your relationship with any Provider. However, Blue Cross and Blue Shield has established Prior Authorization requirements for the specific purpose of assisting you while you determine the course of treatment which will maximize your benefits provided under this Certificate.

Should you fail to notify Blue Cross and Blue Shield as required in the Inpatient Admissions provision of this section for Inpatient Covered Services received from a Participating Provider, you will then be responsible for the first $1,000 or 50%, whichever is less, of the Hospital or facility charges for an eligible stay or the first $1,000 or 50%, whichever is less, of the charges for eligible Covered Services in addition to any Deductibles, Copayments and/or Coinsurance applicable to this Certificate. For Inpatient Covered Services received from a Non-Participating Provider, you will be responsible for the first $500 should you fail to notify Blue Cross and Blue Shield in addition to any Deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any benefit section of this Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate.

**OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW**

**If Prior Authorization is required, the review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate. BCBSIL recommends you confirm with your Provider if Prior Authorization has been obtained.**

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

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

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

**CASE MANAGEMENT**

After your case has been evaluated, you may be assigned a case manager. In some cases, if your condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan. If you and your Physician choose the alternative treatment plan, then alternative benefits will be provided as described in this Certificate.

The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Certificate.

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

**NOTE:** If your Provider determines you are experiencing a high-risk pregnancy, you will have access to clinically-appropriate case management programs.

**LENGTH OF STAY/SERVICE REVIEW**

**Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.**

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


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An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Blue Cross and Blue Shield Physician for review.

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

**CONTACTING BEHAVIORAL HEALTH**

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

**Post-Service Medical Necessity Review**

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

**General Provisions Applicable to All Post-Service Medical Necessity Reviews**

1. **No Guarantee of Payment**

A Post-Service Medical Necessity Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate. Post-Service Medical Necessity Review does not guarantee payment of benefits by the plan, for instance a member may become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. **Request for Additional Information**

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

**MEDICALLY NECESSARY DETERMINATION**

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be based on generally accepted medical standards. Should the Blue Cross and Blue Shield Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates or services that are not in benefit. For further details regarding Medically Necessary care and other exclusions from coverage under this Certificate, see the section titled, "**EXCLUSIONS — WHAT IS NOT COVERED**."

**Blue Cross and Blue Shield does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. Blue Cross and Blue Shield's determination of Medically**


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**Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under this Certificate.**

**Remember that your Blue Cross and Blue Shield Certificate does not cover the cost of hospitalization, or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, Blue Cross and Blue Shield will not pay for the hospitalization, services or supplies if Blue Cross and Blue Shield and the Blue Cross and Blue Shield Physician decide they were not Medically Necessary.**

**APPEAL PROCEDURE**

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

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

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

**Failure to Obtain Prior Authorization**

If Prior Authorization is not obtained:

1. If BCBSIL determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.

2. BCBSIL will review the Medical Necessity of your treatment or service prior to the final benefit determination.


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# BENEFIT INFORMATION

Your employer has chosen Blue Cross and Blue Shield's Blue Options PPO℠ Participating Provider Option ("PPO") Benefit Program for the administration of your Hospital and Physician benefits and all other Covered Services that provide you access to independently contracted Providers participating in the PPO network shown on the Benefit Highlights (the "Network"). This program of health care benefits is designed to provide you with economic incentives for using designated Participating Providers.

As a participant in this Benefit Program, a directory of Providers participating in the Blue Options PPO℠ Network will be available to you. For more information or for a list of Participating Providers, you can contact Customer Service at the toll-free telephone number on the back of your Identification Card, or visit the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com. While there may be changes in the directory from time to time, selection of Participating Providers by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the Network will be provided to your Group Administrator annually, or as otherwise required, to allow you to make a selection within the Network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under this Benefit Program will be greater when you use the services of a Participating Provider.

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

**BENEFIT PERIOD**

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

**YOUR DEDUCTIBLE**

Each Benefit Period you must satisfy the Deductible amount(s) specified in the Benefit Highlights of this Certificate for Covered Services. In other words, after you have Claims for Covered Services for more than the Deductible amount in a Benefit Period, your benefits will begin. This Deductible will be referred to as the program Deductible.

Each time you are admitted to a Hospital you must satisfy the Inpatient Copayment amount (if applicable) specified in the Benefit Highlights of this Certificate.

Each time you receive Covered Services for Outpatient Surgery in a Hospital or Non-Plan Hospital, you must satisfy the Outpatient Surgical Deductible amount (if applicable) specified in the Benefit Highlights of this Certificate. This Deductible is in addition to your program Deductible.

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

**Should the federal government adjust the Deductible(s) and/or out-of-pocket expense limit amount(s) applicable to this type of coverage, the Deductible and/or the out-of-pocket expense limit amount(s) in this Certificate will be adjusted accordingly.**

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

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 Participating Provider program Deductible and/or out-of-pocket expense limit for the first Benefit Period. This special credit applies to eligible expenses incurred for Covered Services within the prior contract's Benefit Period, if not completed. Such expenses can be applied toward the Participating Provider program Deductible and/or out-of-pocket expense limit for the first Benefit Period under this coverage. However, this is only true if your Group had "major medical" type coverage immediately prior to purchasing this coverage.


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**TRANSITION OF CARE BENEFITS**

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

If you are a current covered person under the care of a Participating Provider and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy and your Provider leaves the Network, you may request the option of continuity of care benefits as described in the Continuity of Care provision in the COVERAGE AND PREMIUM INFORMATION Section of this Policy.

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


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# HOSPITAL BENEFIT SECTION

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

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

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

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

The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility.

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

**INPATIENT CARE**

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

**Inpatient Covered Services**

1. Bed, Board and General Nursing Care when you are in:
   a. A semi-private room.
   b. A private room; or
   c. An intensive care unit.
2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work, x-ray, pathology services, magnetic resonance imaging, computed tomography scans and positron emission tomography scans).

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

**Preadmission Testing**

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

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

**Partial Hospitalization Treatment Program**

Benefits are available for this program only if it is a Blue Cross and Blue Shield approved program. Covered Services rendered in a Non-Plan Provider facility will be paid at the Non-Participating Provider facility payment level. No benefits will


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be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield.

**Benefits for Routine Patient Costs for Participants in Approved Clinical Trials**

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

**Inpatient Skilled Nursing Facility Care**

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

**Coordinated Home Care Program**

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

**BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES**

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

Each time you are admitted to a Hospital you will also be responsible for the Inpatient Hospital Deductible amount (if applicable) as specified in the Benefit Highlights of this Certificate.

**Blue Options PPO℠**

When you receive Inpatient Covered Services from a Blue Options PPO℠ Provider or in a Participating Program of a Blue Options PPO℠ Provider, benefits will be provided at the Blue Options PPO℠ Provider Inpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program Deductible and your Inpatient Hospital admission Deductible, unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

If a private room is Medically Necessary, benefits will be based on the Hospital's private room and board rate.

**Participating Provider**

When you receive Inpatient Covered Services from a Participating Provider or in a Plan Program of a Participating Provider, benefits will be provided at the Participating Provider Inpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program Deductible and your Inpatient Hospital admission Deductible, unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

If a private room is Medically Necessary, benefits will be based on the Hospital's private room and board rate.

**Non-Participating Provider**

When you receive Inpatient Covered Services from a Non-Participating Provider or in a Participating Program of a Non-Participating Provider, benefits will be provided at the Non-Participating Provider Inpatient Hospital payment level specified in the Benefit of this Certificate after you have met your program Deductible and your Inpatient Hospital admission Deductible, unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

If a private room is Medically Necessary, benefits will be based on the Hospital's private room and board rate.

**Non-Plan Provider**

When you receive Inpatient Covered Services from a Non-Plan Provider, benefits will be provided at the Non-Plan Provider payment level specified in the Benefit Highlights of this Certificate after you have met your program Deductible and your Inpatient Hospital admission Deductible.

Benefits for an Inpatient Hospital admission to a Non-Plan or Non-Participating Provider resulting from Emergency Accident Care or Emergency Medical Care will be provided such that you will have no greater cost than you would for the same


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Covered Services at a Participating Hospital for that portion of your Inpatient Hospital stay during which your Medically Necessary condition is determined to be unstable and therefore not permitting your safe transfer to a Participating Hospital or other Participating Provider.

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

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

If a private room is Medically Necessary, benefits will be based on the Hospital's private room and board rate.

TO IDENTIFY BLUE OPTIONS, PLAN, PARTICIPATING AND NON-PARTICIPATING HOSPITALS OR FACILITIES, YOU SHOULD CONTACT BLUE CROSS AND BLUE SHIELD BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD OR VISIT THE BLUE CROSS AND BLUE SHIELD WEBSITE AT WWW.BCBSIL.COM FOR A LIST OF PARTICIPATING HOSPITALS.

**OUTPATIENT HOSPITAL CARE**

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

**Outpatient Hospital Covered Services**

1. Surgery and any related Diagnostic Service received on the same day as the Surgery.

   In addition to Surgery in a Hospital, benefits will be provided for Outpatient Surgery performed in an Ambulatory Surgical Facility.

2. Radiation Therapy Treatments.

3. Chemotherapy.

4. Electroconvulsive Therapy.

5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility.

6. Diagnostic Service—when these services are related to Surgery or Medical Care. Such tests include, but are not limited to, x-ray, pathology services, Clinical Laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

7. Urgent Care.

8. Emergency Accident Care.

9. Emergency Medical Care.

10. Mammograms—Benefits for mammograms will be provided at the benefit payment level described in the **SPECIAL CONDITIONS AND PAYMENTS** section of this Certificate.

11. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section titled," preventive care services" in the **SPECIAL CONDITIONS AND PAYMENTS** section of this Certificate.

12. Prostate Test and Digital Rectal Examination—Unless otherwise stated, benefits will be provided at the benefit payment level described in the section titled, "preventive care services" in the **SPECIAL CONDITIONS AND PAYMENTS** section of this Certificate.

13. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section titled, "preventive care services" in the SPECIAL


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CONDITIONS AND PAYMENTS section of this Certificate.

14. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section titled, "preventive care services" in the **SPECIAL CONDITIONS AND PAYMENTS** section of this Certificate.

15. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section titled, "preventive care services" in the **SPECIAL CONDITIONS AND PAYMENTS** section of this Certificate.

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

17. Rehabilitative Services.

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

**BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES**

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

Each time you are admitted to a Hospital or Non-Plan Hospital you will also be responsible for the Outpatient Hospital Deductible amount (if applicable) as shown on the Benefit Highlights of this Certificate.

**Participating Provider** Benefits will be provided at the Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program Deductible and any applicable Outpatient Surgery Deductible when you receive Outpatient Hospital Covered Services from a Participating Provider, unless otherwise specified in this Certificate.

**Non-Participating Provider.** When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at the Non-Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program Deductible and any applicable Outpatient Surgery Deductible, unless otherwise specified in this Certificate.

**Non-Plan Provider** When you receive Outpatient Hospital Covered Services from a Non-Plan Provider, benefits will be provided at the Non- Plan Provider payment level specified in the Benefit Highlights of this Certificate after you have met your program Deductible and any applicable Outpatient Surgery Deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Plan Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Provider. Non-Emergency services provided in a Hospital emergency department for treatment of Mental Illness or Substance Use Disorder will be paid the same as Emergency Medical Care and Emergency Accident Care services.


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**Urgent Care**

Each time you receive Covered Services in an Urgent Care facility, you will be responsible for an Urgent Care facility Copayment amount specified in the Benefit Highlights in this Certificate. Any additional Covered Services received in the Urgent Care facility will be provided at the payment level for Outpatient Hospital Covered Services.

**Emergency Care**

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

Benefits for Emergency Accident Care will be subject to the program Deductible.

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

Benefits for Emergency Medical Care will be subject to the program Deductible.

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

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

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

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

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

**NOTE**: Prior Authorization is not required for coverage of emergency care.

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

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

If you must receive Medically Necessary Hospital Covered Services which are determined to be unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided such that you will have no greater cost than if you received the Covered Services at a Participating or Participating Professional Provider.

**BENEFIT DIFFERENTIALS FOR COVERED SERVICES IN HOSPITAL AND FREESTANDING FACILITY**

Benefits for certain services will vary depending on whether the service was received in a Hospital or a Freestanding Facility. A Freestanding Facility may include but is not limited to Ambulatory Surgical Centers and Mobile Imaging Centers.

Benefits for Outpatient Surgery, Outpatient Advanced Imaging, Outpatient Basic Radiology X-Ray and Diagnostic Imaging and Outpatient Laboratory Services will be at the benefit level set forth in the Benefit Highlights. Members' out-of-pocket expenses may be lower when Services are received in a Freestanding Facility instead of a Hospital.


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You can review the Provider Directory to find Independent Freestanding Facility locations for treatment in your area or you can call the customer service toll-free number on your identification card. Further, these cost differentials, if any, only apply to Participating Provider Claims.


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# PHYSICIAN BENEFIT SECTION

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

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

For benefits to be available, under this Benefit Section, please note that services must be determined to be Medically Necessary by the Plan in order to be covered under this Certificate.

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

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

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

## ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE

You are not required to obtain authorization or a referral from Blue Cross and Blue Shield, a Primary Care Provider, or any other person when you seek coverage for obstetrical or gynecological care provided by a licensed or certified Participating health care professional who specializes in obstetrics or gynecology.

## COVERED SERVICES

### Long-term Antibiotic Therapy

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

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


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**Pediatric Neuromuscular, Neurological, or Cognitive Impairment**

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

**Surgery**

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

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

The following services are also part of your surgical benefits:

1. **Anesthesia Services**

   Benefits are available for Medically Necessary anesthesia services, regardless of duration, If administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. Benefits will also be provided for Anesthesia Services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

   In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 26 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

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

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

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

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

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

   b. It manifested before the age of 22.


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c. It is likely to continue indefinitely; and

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

2. **Assist at Surgery**

When performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.

3. **Sterilization Procedures** (even if they are voluntary)

Benefits for sterilization procedures and follow-up services will not be subject to any Deductible, Coinsurance and/or Copayment when such services are received from a Participating Provider, except for male sterilization procedures and follow-up services, will not be subject to any Coinsurance and/or Copayment after your program Deductible has been met.

**A1C TESTING**

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

**PANCREATIC CANCER SCREENING**

This plan provides benefits for Medically Necessary pancreatic cancer screenings.

**VITAMIN D TESTING**

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

**Additional Surgical Opinion**

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

**Medical Care**

Benefits are available for Medical Care visits when:

1. You are an Inpatient in a Hospital, a Substance Use Disorder Treatment Facility, a Residential Treatment Facility, or a Skilled Nursing Facility; or

2. You are a patient in a Partial Hospitalization Treatment Program or a Coordinated Home Care Program; or

3. You visit your Physician's office, or your Physician comes to your home.

**Consultations**

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

**Diabetes Self-Management Training and Education**

Benefits will be provided for Outpatient self-management training, education, and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered, or licensed health care professional with


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expertise in diabetes management, operating within the scope of their license or certification. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the **OTHER COVERED SERVICES** section of this Certificate. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

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

**Allergy Injections and Allergy Testing**

This plan provides benefits for allergy injections and allergy testing.

**Chemotherapy**

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

**Occupational Therapy**

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

**Physical Therapy**

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

**Routine Foot Care**

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

**Radiation Therapy Treatments**

This plan provides benefits for Medically Necessary radiation therapy treatments, including proton beam therapy.

**Reconstructive Services**

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

**Electroconvulsive Therapy**

**Speech Therapy**

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Speech Therapy visit maximums, if any, shown in the *Benefit Highlights* section under this Certificate.

**Clinical Breast Examinations**


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Benefits will be provided for, at minimum, every three years for individuals at least 20 years of age but less than 40 years of age and annually for individuals 40 years of age or older clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician. Benefits for Clinical Breast Examinations will be provided at the benefit payment level described in the **SPECIAL CONDITIONS AND PAYMENTS** section of this Certificate.

**Breast Cancer Pain Medication and Therapy**

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

**Fibrocystic Breast Condition**

Benefits will be provided for Covered Services related to Fibrocystic Breast Condition.

**Diagnostic Service**

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

**Mammograms**

Benefits for mammograms will be provided at the benefit payment level described in the **SPECIAL CONDITIONS AND PAYMENTS** section of this Certificate.

**Pap Smear Test**

Benefits will be provided for an annual routine cervical smear or pap smear test. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section titled, “preventive care services” in the **SPECIAL CONDITIONS AND PAYMENTS** section of this Certificate.

**Prostate Cancer Screening**

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

**Human Papillomavirus Vaccine**

Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section titled, “preventive care services” in the **SPECIAL CONDITIONS AND PAYMENTS** section of this Certificate. If you obtain the vaccine at a Pharmacy, benefits will be provided at the benefit payment level described in the provision titled, “Vaccinations obtained through Participating Pharmacy Providers” in the **OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION** of this Certificate.

**Shingles Vaccine**

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

**Routine Liver Screening**

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

**Ovarian Cancer Screening**

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

**Colorectal Cancer Screening**


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Benefits will be provided for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section titled, "preventive care services" in the **SPECIAL CONDITIONS AND PAYMENTS** section of this Certificate.

**Biomarker Testing**

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

**Bone Mass Measurement and Osteoporosis**

This plan provides Benefits for bone mass measurement and the diagnosis and treatment of osteoporosis.

**Breast Reduction Surgery**

This plan provides benefits for Medically Necessary breast reduction surgery.

**Cleft Lip and Palate**

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

**Experimental/Investigational Treatment**

Benefits will be provided for routine patient care in conjunction with Experimental/Investigational treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your Physician is considered Life Threatening Disease or Condition, if:

a) you are a qualified individual participating in an Approved Clinical Trial program; and

b) if those services or supplies would otherwise be covered under this 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 your identification card in advance to obtain information about whether a particular clinical trial is qualified.

**Emergency Accident Care Emergency Medical Care**

Chiropractic and Osteopathic Manipulation

Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 25 visits per Benefit Period.

**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.

**Durable Medical Equipment**

Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, Complex Rehabilitation Technology (includes Medically Necessary repairs and associated rental of Complex Rehabilitation Technology during those repairs),


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compression sleeves to prevent or mitigate lymphedema, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of cardiopulmonary monitors (18 years old or younger) or durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

**Blood Glucose Monitors for Treatment of Diabetes**

Benefits are available for Medically Necessary blood glucose monitors (including continuous glucose monitors, non-invasive monitors and monitors for the blind) for which a Health Care Practitioner has written an order. This coverage also includes related supplies, and training in the use of continuous glucose monitors. Benefits for glucose monitors will be provided at no charge when obtained from a Participating Provider, after your program Deductible has been met.

**Prosthetic Appliances**

Benefits will be provided 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.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

**Orthotic Devices**

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

**Outpatient Contraceptive Services**

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

Benefits for Outpatient contraceptive services will not be subject to any Deductible, Coinsurance and/or Copayment when such services are received from a Participating Provider.

**Amino Acid-Based Elemental Formulas**

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

**Alzheimer's Disease and Related Dementias**

This plan provides benefits for Medically Necessary diagnostic testing for Alzheimer's disease or related dementias, and FDA-approved treatments or medications prescribed to slow the progression of Alzheimer's Disease or related dementias, as determined by a Physician.


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**Laser Hair Removal**

This plan provides benefits for Medically Necessary laser hair removal procedures, when prescribed in accordance with generally accepted standards of medical care.

**Hippotherapy**

This plan provides benefits for Medically Necessary services that incorporate equine movement as part of a therapeutic intervention, including Hippotherapy.

**Klinefelter Syndrome**

This plan provides benefits for karyotype or related hormonal testing to diagnose Klinefelter Syndrome.

**Routine Pediatric Hearing Examination**

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

**Pulmonary Rehabilitation Therapy**

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

**Massage Therapy**

This plan provides benefits for Medically Necessary massage therapy.

**Medical Drug Benefit Program**

Certain prescription drugs administered by a health care professional may be covered under this Benefit section. Coverage is based on recommendations of a committee, which is made up of physicians and pharmacists from across the country, some of whom are affiliated with BCBSIL. The committee considers existing FDA-approved drugs, as well as newly FDA-approved drugs, using factors including but not limited to, safety, effectiveness, cost, and how they compare with other Covered prescription drugs.

**Medical Drug Benefit Review and Limitations**

The following rules apply to prescription drugs which may be covered under this Benefit section:

Accelerated FDA-approved drugs: If your Provider submits a request for an exception for a noncovered prescription drug which may be administered by a health care professional that has been approved by the FDA through the accelerated approval program, coverage will be determined by the Plan after reviewing for Medical Necessity.

New FDA-approved drugs: If your Provider submits a request for an exception for a noncovered prescription drug which may be administered by a health care professional that has recently received FDA approval, coverage will be determined by the Plan after reviewing for Medical Necessity.

Self-administered formulations: Select medications may be excluded from coverage under this Benefit section when a self-administered formulation of the drug is available.

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

**NOTE**: To learn more about prescription drugs that may be covered under this Benefit section or about how to request an exception, you, your Provider, or your authorized representative 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.


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For prescription drugs that are not otherwise covered under this Benefit section, your Provider may request an exception by submitting a completed Medical Drug Benefit Program Coverage Exception Request form available at www.bcbsil.com/docs/provider/il/education/forms/il-mbta-exception-request.pdf. Notice of coverage determinations will be provided to you and your Provider.

**Tobacco Use Screening and Smoking Cessation Counseling Services**

**Tobacco Cessation Drugs**

**Testing, Screening, Vaccinations, and Treatment obtained through Pharmacies**

This plan provides benefits for select Covered vaccinations, including testing, screening and treatments through certain Pharmacies that have contracted with Blue Cross and Blue Shield to provide this service. To locate a contracting Pharmacy in your area, call the Customer Service toll-free number on your Identification Card. At the time you receive services, present your Blue Cross and Blue Shield Identification Card to the pharmacist. This will identify you as a participant in the Blue Cross and Blue Shield health care plan provided by your employer. The pharmacist will inform you of the amount for which you are responsible for, if any.

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

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

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

**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, after your program deductible has been met.

**Growth Hormone Therapy**

This plan provides benefits for Medically Necessary growth hormone therapy.

**Therapies to Treat Menopause**

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

**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.

**Vaginal Estrogen**

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

**Immune Gamma Globulin Therapy (IGGT)**


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Benefits will be provided for immune gamma globulin therapy for covered persons diagnosed with a primary immune deficiency when prescribed as Medically Necessary by a Physician. Nothing shall prevent Blue Cross and Blue Shield from applying appropriate utilization review standards to the ongoing coverage of IGGT for persons diagnosed with a primary immunodeficiency. Subject to such utilization review standards, an initial authorization shall be for no less than three months and reauthorization may occur every six months thereafter. For persons who have been in treatment for two years, reauthorization shall be no less than every 12 months, unless more frequently indicated bya Physician.

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

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

**Breast Implant Removal**

**Cardiovascular Disease Management**

**HIV Screening and Counseling**

Benefits will be provided HIV Screening and Counseling and prenatal HIV testing ordered by a Physician, Physician Assistant or Advanced Practice Registered Nurse who has a written collaborative agreement with a collaborating Physician that authorizes these services, including but not limited to orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

**BENEFIT PAYMENT FOR PHYSICIAN SERVICES**

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

**Participating Provider**

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

When you receive Covered Services (except for those services specified below) in a Participating Provider's office (other than a specialist's office), benefits for Covered Services, including all related Covered Services received on the same day, are subject to the Physician's office Copayment amount (if applicable) specified in the Benefit Highlights of this Certificate. Benefits will then be provided at the Physician's office payment level specified in the Benefit Highlights of this Certificate. Your program Deductible will not apply.

When you receive Covered Services (except for those services specified below) in a Participating Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to the Participating Provider's specialist office Copayment amount (if applicable) specified in the Benefit Highlights of this Certificate. Benefits will then be provided at the specialist's office payment level specified in the Benefit Highlights of this Certificate. Your program Deductible will not apply.

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

Benefits for certain Diagnostic tests may require a Copayment or Coinsurance Amount specified in the Benefit Highlights section of this Certificate.

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

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

1. Behavioral Health Practitioner.
2. Certified Nurse-Midwife.
3. Certified Nurse Practitioner.
4. Certified Clinical Nurse Specialist.
5. Clinical Laboratory.
6. Clinical Professional Counselor.
7. Clinical Psychology.
8. Clinical Social Worker.
9. Family Practice.
10. General Practice.
11. Gynecology.
12. Internal Medicine.
13. Marriage and Family Therapist.
14. Mixed psychiatric group.
15. Mixed specialty group.
16. Neuro Psychologist.
17. Optician.
18. Optometrist.
19. Obstetrics.
20. Obstetrics/Gynecology.
21. Pediatrics.
22. Psychiatry; and
23. Retail Health Clinic; or a Physician.

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

1. Surgery.
2. Occupational Therapy.
3. Physical Therapy.
4. Speech Therapy.
5. Chiropractic and osteopathic manipulation.
6. Diagnostic Services; and
7. Magnetic resonance imaging computed tomography scans and positron emission tomography scans.

**Non-Participating Provider**


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When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at the Non-Participating Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights of this Certificate after you have met your program Deductible.

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

**Emergency Care**

Benefits for Emergency Accident Care will be provided at the Emergency Accident Care payment level specified in the Benefit Highlights of this Certificate when rendered by either a Participating or Non-Participating Provider. Your program Deductible will apply.

Benefits for Emergency Medical Care will be provided at the Emergency Medical Care payment level specified in the Benefit Highlights of this Certificate when rendered by either a Participating or Non-Participating Provider. Your program Deductible will apply.

Benefits for Mental Illness will be provided at the Mental Illness payment level specified in the Benefit Highlights of this Certificate when rendered by either a Participating or Non-Participating Provider in a Hospital emergency department. Your program Deductible will apply.

Benefits for Substance Use Disorder will be provided at the Substance Use Disorder payment level specified in the Benefit Highlights of this Certificate when rendered by either a Participating or Non-Participating Provider in a Hospital emergency department. Your program Deductible will apply.

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

**This Copayment amount is subject to change or increase as permitted by applicable law or regulatory guidance. Participating Providers are:**

1. Acupuncturists.
2. Audiologists.
3. Physicians.
4. Podiatrists.
5. Psychologists.
6. Certified Clinical Nurse Specialists.
7. Certified Nurse-Midwives.
8. Certified Nurse Practitioners.
9. Certified Registered Nurse Anesthetists.
10. Chiropractors.
11. Clinical Laboratories.
12. Clinical Professional Counselors.
13. Clinical Social Workers.
14. Durable Medical Equipment Providers.


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15. Naprapaths.
16. Home Infusion Therapy Providers.
17. Marriage and Family Therapists.
18. Occupational Therapists.
19. Optometrists.
20. Orthotic Providers.
21. Physical Therapists.
22. Prosthetic Providers.
23. Registered Dietitians.
24. Registered Surgical Assistants.
25. Retail Health Clinics.
26. Speech Therapists; and
27. Other Professional Providers.

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

**Non-Participating Providers are:**

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


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19. Occupational Therapists.
20. Optometrists.
21. Orthotic Providers.
22. Physical Therapists.
23. Prosthetic Providers.
24. Registered Dietitians.
25. Registered Surgical Assistants.
26. Retail Health Clinics.
27. Speech Therapists; and
28. Other Professional Providers.

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

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

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

1. If two or more surgical procedures are related or performed in the same operative area and are performed by the same or different Physician, Dentist or Podiatrist during the same operation, benefits will be provided only for the procedure which has the larger Maximum Allowance.


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# OTHER COVERED SERVICES

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

1. The processing, transporting, storing, handling and administration of blood and blood components.
2. Private Duty Nursing Service—Benefits for Private Duty nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non- professional personnel and can only be provided by a licensed health care Provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
3. Ambulance Transportation—When your condition is such that an ambulance is Medically Necessary. Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation when rendered in connection with a covered Inpatient admission or covered Emergency Medical Care.

   **NOTE**: Cost sharing requirements for ground ambulance services obtained from a Nonparticipating Provider, will not exceed the cost sharing requirements for ground ambulance services obtained from a Participating Provider.
4. Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
5. Oxygen and its administration.
6. Medical and surgical dressings, supplies, casts and splints.
7. Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of 15 visits per Benefit Period.
8. Wigs—Benefits will be provided for one wig per Benefit Period (also referred to as scalp prostheses) for hair loss caused by:
   a. Chemotherapy
   b. Radiation therapy for cancer or other conditions; or
   c. Alopecia.
9. Hearing Implants—Benefits will be provided for bone-anchored Hearing Aids and cochlear implants.
10. Hearing Aids—Benefits will be provided for Medically Necessary Hearing Aids when a Hearing Care Professional prescribes a Hearing Aid to augment communication as follows:
    a. One Hearing Aid will be covered for each ear every 24 months.
    b. Related services, such as audiological examination 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
    c. Hearing Aid repairs will be covered when deemed Medically Necessary.

**BENEFIT PAYMENT FOR OTHER COVERED SERVICES**

Benefits for Other Covered Services will be provided at the Other Covered Services payment level specified in the Benefit Highlights of this Certificate after you have met your calendar year Deductible for any of the Covered Services described in this section.

Notwithstanding anything else described herein, Providers of Ambulance Transportation will be paid based on the Ambulance Transportation Eligible Charge. Benefits for Ambulance Transportation will be provided at the Other Covered Services benefit payment level as shown on the Benefit Highlights of this Certificate after you have met your Benefit Period Deductible.


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

**Participating Providers are:**

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

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


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**Non-Participating Providers are:**

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

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

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


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## SPECIAL CONDITIONS AND PAYMENTS

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

**HUMAN ORGAN TRANSPLANTS**

Your benefits for certain Medically Necessary human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, musculoskeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants.

Benefits are available to both the recipient and donor of a covered transplant as follows:

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

Benefits will be provided for:

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

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

1. Whenever a heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplant is recommended by your Physician, you must contact Blue Cross and Blue Shield by telephone before your transplant Surgery has been scheduled. Blue Cross and Blue Shield will furnish you with the names of Hospitals that have Blue Cross and Blue Shield approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants performed at any Hospital that does not have a Blue Cross and Blue Shield approved Human Organ Transplant Coverage Program.
2. Your benefits under this coverage will begin no earlier than 5 days prior to the transplant Surgery and shall continue for a period of no longer than 365 days after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.
3. Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.
4. If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and one or two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
5. Benefits for transportation and lodging will be provided at 100% of the Transplant Lodging Eligible Expense. Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.
6. In addition to the other exclusions of this Certificate, benefits will not be provided for the following:
    a. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.


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b. Transportation by air ambulance for the donor or the recipient.

c. Travel time and related expenses required by a Provider.

d. Drugs which are Experimental/Investigational.

e. Drugs which do not have approval of the Food and Drug Administration.

f. Storage fees.

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

h. Meals.

**CARDIAC REHABILITATION SERVICES**

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

**Preventive Care Services**

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

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

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

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

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

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

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

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

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

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

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

1. Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked.
2. Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions.
3. Unhealthy alcohol and drug use screening and counseling.
4. Aspirin use for men and women for prevention of cardiovascular disease for certain ages.
5. Blood pressure screening.
6. Cholesterol screening for adults of certain ages or at higher risk.
7. Colorectal cancer screening for adults over age 45.
8. Whole body skin examination for lesions suspicious for skin cancer.
9. Mental health prevention and wellness visit.
10. Depression screening.
11. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease.
12. HIV screening for all adults at higher risk.
13. HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition, including baseline and monitoring services.
14. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    a. COVID-19.
    b. Haemophilus influenzae type b (Hib).
    c. Hepatitis A.
    d. Hepatitis B.
    e. Herpes Zoster (Shingles).
    f. Human papillomavirus.
    g. Influenza (Flu shot or Flu mist).
    h. Measles, Mumps, Rubella.
    i. Meningococcal.
    j. MPOX.
    k. Pneumococcal.
    l. RSV.
    m. Tetanus, Diphtheria, Pertussis(DTap/Tdap/Td).
    n. Varicella.
15. Obesity screening and counseling.
16. Sexually transmitted infections (STI) counseling.
17. Tobacco use screening and cessation interventions for Tobacco users.
18. Syphilis screening for adults at higher risk.
19. Exercise interventions to prevent falls in adults aged 65 years and older who are at increased risk for falls;


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20. Hepatitis C virus (HCV) screening for infection in adults aged 18 to 79 years.
21. Hepatitis B virus screening for persons at high risk for infection.
22. Counseling children, adolescents, and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
23. Lung cancer screening in adults 50 and older who have a 20-pack per year smoking history and currently smoke or have quit within the past 15 years.
24. Screening for high blood pressure in adults aged 18 years or older;
25. Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese.
26. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history of CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking), and (c) a calculated 10-year CVD risk of 10% or greater; and
27. Tuberculin testing for adults 18 years or older who are at a higher risk of tuberculosis.

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

1. Bacteriuria urinary tract screening or other infection screening for pregnant women.
2. BRCA counseling about genetic testing for women at higher risk; and, if recommended by a Provider after counseling, BRCA genetic testing.
3. Breast cancer chemoprevention counseling for women at higher risk.
4. Breastfeeding comprehensive lactation support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Electric breast pumps are limited to 1 per Benefit Period.
5. Cervical cancer screening.
6. Chlamydia infection screening for younger women and women at higher risk.
7. Contraception: Certain FDA approved contraceptive methods, sterilization procedures, and patient education and counseling.
8. Domestic and interpersonal violence screening and counseling for all women.
9. Daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant.
10. Diabetes screening after pregnancy.
11. Female and male condoms.
12. Gestational diabetes screening for women after 24 weeks pregnant and those at high risk of developing gestational diabetes.
13. Gonorrhea screening for all women.
14. Hepatitis B screening for pregnant women at their first prenatal visit.
15. HIV screening and counseling for women.
16. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older.
17. Osteoporosis screening for women over age 65, and younger women with risk factors.
18. Perinatal depression screening and counseling.
19. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
20. Tobacco use screening and interventions for all women and expanded counseling for pregnant Tobacco users.


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21. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened.
22. Sexually transmitted infections (STI) counseling for women.
23. Syphilis screening for all pregnant women or other women at increased risk.
24. Well woman visits to obtain recommended preventive services.
25. Urinary incontinence screening.
26. Breast cancer mammography screening, including breast tomosynthesis and, if determined to be Medically Necessary by a Physician, Advanced Practice Nurse or a Physician Assistant, a screening MRI and comprehensive ultrasound. Also covers additional imaging and pathology evaluation, if indicated to complete the initial screening for malignancies.
27. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal.
28. Aspirin use for pregnant women to prevent preeclampsia; and
29. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
30. Behavioral counseling to promote healthy weight gain during pregnancy.
31. Behavioral counseling to maintain weight or limit weight gain to prevent obesity for women who are aged 40 or older.
32. Menopause health visit.
33. Clinical breast examinations

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

1. Alcohol and drug use assessment for adolescents.
2. Behavioral assessments for children of all ages.
3. Blood pressure screenings for children of all ages.
4. Cervical dysplasia screening for females.
5. Congenital hypothyroidism screening for newborns.
6. Critical congenital heart defect screening for newborns.
7. Depression disorder screening for adolescents.
8. Development screening for children under age 3, and surveillance throughout childhood.
9. Dyslipidemia screening for children ages 9-11 and 17-21.
10. Bilirubin screening in newborns.
11. Fluoride chemoprevention supplements for children without fluoride in their water source.
12. Fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.
13. Gonorrhea preventive medication for the eyes of all newborns.
14. Hearing screening for all newborns, children, and adolescents.
15. Height, weight, and body mass index measurements.
16. Hematocrit or hemoglobin screening.
17. Hemoglobinopathies or sickle cell screening for all newborns.


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18. HIV screening for adolescents at higher risk.
19. Whole body skin examination for lesions suspicious for skin cancer.
20. Mental Health prevention and wellness visit.
21. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    a. COVID-19.
    b. Haemophilus influenzae type b.
    c. Hepatitis A.
    d. Hepatitis B.
    e. Human papillomavirus.
    f. Inactivated Poliovirus.
    g. Influenza (Flu shot or Flu mist).
    h. Measles, Mumps, Rubella.
    i. Meningococcal.
    j. Pneumococcal.
    k. Rotavirus.
    l. RSV.
    m. Tetanus, Diphtheria, Pertussis (DTap/Tdap/Td).
    n. Varicella.
22. Lead screening for children at risk for exposure.
23. Medical history for all children throughout development.
24. Obesity screening and counseling.
25. Oral health risk assessment for younger children up to six years old.
26. Phenylketonuria (PKU) screening for newborns.
27. Sexually transmitted infections (STI) prevention and counseling for adolescents.
28. Tuberculin testing for children at higher risk of tuberculosis.
29. Vision screening for children and adolescents.
30. Autism screening for children at 18 and 24 months of age.
31. Tobacco use interventions, including education or counseling, to prevent initiation of Tobacco use in school-aged children and adolescents.
32. Newborn blood screening; and
33. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

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


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Preventive Drug List that are obtained from a non-Participating Pharmacy Provider, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.

A copay waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

The FDA approved contraceptive drugs and devices currently covered under this benefit provision are listed on the *Contraceptive Coverage List*. This list is available on our website at www.bcbsil.com and by contacting customer service at the toll-free number on your identification card. Benefits are not available under this benefit provision for Contraceptive drugs and devices not listed on the *Contraceptive Coverage List*. You may, however, have coverage under other sections of this Certificate, subject to any applicable Coinsurance, Copayments, Deductibles and/or benefit maximum. The *Contraceptive Coverage List* and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

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

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

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

Vaccinations that are received from a Non-Participating Provider, a Non-Plan Provider facility, or a Non-Participating Pharmacy Provider or other routine Covered Services not provided for under this provision may be subject to the Deductible, Coinsurance, Copayments and/or benefit maximums.

**IN HOME HEALTH ASSESSMENT**

Benefits are available for an annual in-home health assessment performed by Advanced Practice Nurses and/or Physicians. Covered Services may include, but not limited to, health history and blood pressure and blood sugar level screening. The assessment is designed to provide you with information regarding your health that can be discussed with your health care Provider and is not a substitute for diagnosis management and treatment by your health care Provider.

Benefits for the in-home health assessment will not be subject to any Deductible, Copayment or Coinsurance when received from a Participating Provider.

**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 nervus 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.

**SKILLED NURSING FACILITY CARE**

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

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

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

Benefits for Covered Services rendered in a Participating Skilled Nursing Facility will be provided at the Participating Provider Inpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program Deductible.


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Benefits for Covered Services rendered in a Non-Plan Skilled Nursing Facility will be provided at the Non-Plan Provider payment level specified in the Benefit Highlights of this Certificate once you have met your program Deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

**AMBULATORY SURGICAL FACILITY**

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

Benefits for services rendered by a Plan Ambulatory Surgical Facility will be provided at the Participating Provider Freestanding Facility payment level specified under the Outpatient Surgical/Medical Services provision in the Benefit Highlights of this Certificate. Benefits for services by a Non-Plan Ambulatory Surgical Facility will be provided at the Non-Plan Provider payment level specified under the Non-Plan Provider provision in the Benefit Highlights of this Certificate.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program Deductible or any applicable Outpatient Copayment.

**SUBSTANCE USE DISORDER TREATMENT**

Benefits for all of the Covered Services described in this Certificate are available for Substance Use Disorder Treatment. In addition, benefits will be provided for these Covered Services for Substance Use Disorder Treatment in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Treatment in a Residential Treatment Center. Substance Use Disorder Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Participating Provider facility payment level.

**DETOXIFICATION**

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

**MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES**

Benefits for all of the Covered Services described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Benefits for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder includes pregnancy and postpartum periods and are available for those who have experienced a miscarriage or stillbirth. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license.

If you require Medically Necessary Mental Illness or Substance Use Disorder services and receive a network exception because they are not available from a Participating Provider, reasonable reimbursement for food, lodging, and travel costs will also be available, if a claim is submitted within sixty (60) days of the last date of the Covered health care service for which travel was required. Reimbursement for food and lodging will be at the prevailing federal per diem rates then in effect, as set by the United States General Services Administration. Reimbursement for travel expenses for miles driven will be at the current Internal Revenue Service mileage standard. This reimbursement will not be available if the Provider is outside the state of Illinois and more than 100 miles from your residence, unless you are unable to obtain the Medically Necessary Mental Illness or Substance Use Disorder service within those parameters within ten (10) business days of a request for appointment.

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

**BARIATRIC SURGERY**

Benefits for Covered Services received for Bariatric Surgery will be provided under the **HOSPITAL BENEFITS** and **PHYSICIAN BENEFITS** section of this Certificate, the same as for any other condition.

**AUTISM SPECTRUM DISORDER(S)**

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

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

Prior Authorization will assess whether services meet coverage requirements. Review the **OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW** provision of the **BEHAVIORAL HEALTH UNIT** section of this Certificate for more specific information about Prior Authorization.

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

**HABILITATIVE SERVICES**

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

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

**EARLY TREATMENT OF A SERIOUS MENTAL ILLINESS**

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

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

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

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

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

**MATERNITY SERVICE**


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

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

a) the routine Inpatient Hospital nursery charges.

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

c) one Inpatient hearing screening.

If the newborn child needs treatment for an illness, injury, congenital defect (including Medically Necessary treatment of cleft lip and palate), birth abnormalities, and premature birth, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of the date of birth. Your Family Coverage will then be effective from the date of birth.

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

**OTHER REPRODUCTIVE HEALTH SERVICES**

Your coverage includes benefits for abortion care. Benefits for abortion care will be provided at no cost, after your program deductible has been met.

**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.

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

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


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

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

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

Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

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

**Special Limitations**

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

**FERTILITY PRESERVATION SERVICES**

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

**HUMAN BREAST MILK COVERAGE**

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

1. The milk is prescribed by a licensed medical practitioner.
2. The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
3. The infant's mother/birthing parent is medically or physically unable to produce breast milk or produce breast milk in sufficient quantities to meet the infant's needs or the mother/birthing parent's breast milk is contraindicated.
4. The milk has been determined to be Medically Necessary for the infant; and


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5. One or more of the following applies:

   a. The infant's birth weight is below 1,500 grams.

   b. The infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

   c. The infant has infant hypoglycemia.

   d. The infant has congenital heart disease.

   e. The infant has had or will have an organ transplant.

   f. The infant has sepsis; or

   g. The infant has any other serious congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the infant.

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

1. The milk is prescribed by a licensed medical practitioner.

2. The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.

3. The infant's mother/birthing parent is medically or physically unable to produce breast milk or produce breast milk in sufficient quantities to meet the infant's needs or the mother/birthing parent's breast milk is contraindicated.

4. The milk has been determined to be Medically Necessary for the infant; and

5. One or more of the following applies:

   a. The child has spinal muscular atrophy.

   b. The child's birth weight was below 1,500 grams and they have long-term feeding or gastrointestinal complications related to prematurity.

   c. The child has had or will have an organ transplant; or

   d. The child has a congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the child.

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

**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.

**MAMMOGRAMS**

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

1. One baseline mammogram.

2. An annual mammogram.

Benefits for routine mammograms will be provided for individuals who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at the age and intervals considered medically Necessary by their Physician.


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

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

Benefits for routine mammograms will be provided at 100% of the Eligible Charge or Maximum Allowance, whether or not you have met your program deductible. Benefits for Diagnostic Mammograms will be provided at 100% after your program deductible has been met.

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

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

**Blue Options PPO℠ Provider**

Benefits for routine mammograms will not be subject to any Deductible, Coinsurance or Copayment when such services are received from a Blue Options PPO℠ Provider.

**Participating Provider**

Benefits for routine mammograms will not be subject to any Deductible, Coinsurance or Copayment when such services are received from a Participating Provider.

**Non-Participating Provider**

Benefits for routine mammograms when rendered by a Non-Participating Provider will be provided at the Non- Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate.

**Benefit Maximum**

Benefits for routine mammograms will not be subject to any Benefit Period maximum or lifetime maximum.

**Diagnostic Colonoscopies**

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

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

**MASTECTOMY-RELATED SERVICES**

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge.
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; and
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not


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covered unless medically necessary. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

**TELEHEALTH and TELEMEDICINE SERVICES**

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

**VIRTUAL VISITS**

Benefits will be provided for Covered Services described in this Certificate for the diagnosis and treatment of non-emergency medical and behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit. Covered Services received through a Virtual Visit must be rendered by a Virtual Provider who has a specific agreement with Blue Cross and Blue Shield to provide Virtual Visits.

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

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

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

**PAYMENT PROVISIONS**

**Lifetime Maximum**

The total dollar amount that will be available in benefits for you, under this Certificate, is unlimited.

**Cumulative Benefit Maximums**

All benefits payable under this Certificate are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service, Blue Cross and Blue Shield will include benefit payments under both this and/or any prior or subsequent Blue Cross and Blue Shield Certificate issued to you as an Eligible Person or a Dependent of an Eligible Person under this Group.

**OUT-OF-POCKET EXPENSE LIMIT**

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Blue Options PPO℠ Providers, Participating Providers and Non-Participating Providers.

**For Blue Options PPO℠ Providers**

If, during one Benefit Period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights of this Certificate, any additional eligible Claims for Blue Options PPO℠ Providers (except for those Covered Services specifically excluded below) during that Benefit Period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

1. The payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Plan Providers other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is unstable).

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

1. Charges that exceed the Eligible Charge or Maximum Allowance.


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2. The Coinsurance resulting from Covered Services rendered by a Non-Participating or Non-Plan Provider.
3. Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Behavioral Health Unit.
4. Services, supplies, or charges limited or excluded in this Certificate.
5. Expenses not covered because a benefit maximum has been reached.
6. Benefit reductions resulting from receiving Specialty and Complex Care Drugs from a Pharmacy that is not a Specialty Pharmacy Provider.
7. Benefit reductions resulting from receiving Prescription Drugs from a Non-Participating Pharmacy Provider If you have Family Coverage, each member of your family must satisfy the out-of-pocket expense limit.

**For Participating Providers**

If, during one Benefit Period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights of this Certificate, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that Benefit Period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

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

1. Charges that exceed the Eligible Charge or Maximum Allowance.
2. The Coinsurance resulting from Covered Services rendered by a Non-Participating or Non-Plan Provider; and
3. Copayments resulting from noncompliance with the provisions of the Medical Services Advisory and/or the Blue Cross and Blue Shield Behavioral Health Unit.
4. Services, supplies, or charges limited or excluded in this Certificate.
5. Expenses not covered because a benefit maximum has been reached.
6. Benefit reductions resulting from receiving Specialty and Complex Care Drugs from a Pharmacy that is not a Specialty Pharmacy Provider; and
7. Benefit reductions resulting from receiving Prescription Drugs from a Non-Participating Pharmacy Provider.

If you have Family Coverage, each member of your family must satisfy the out-of-pocket expense limit.

**For Non-Participating Providers**

If, during one Benefit Period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights of this Certificate, any additional eligible Claims for Non-Participating Providers or Non-Plan Providers (except for those Covered Services specifically excluded below) during that Benefit Period will be paid at 100% of the Eligible Charge or Maximum Allowance..

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

The Non-Participating or Non-Plan Provider Program Deductible

1. The Hospital emergency room per occurrence Deductible
2. The Non-Participating or Non-Plan Provider Inpatient Deductible
3. The Non-Participating or Non-Plan Provider Outpatient Surgical Deductible
4. The deductible amount for Diagnostic Services
5. The payments for Covered Services rendered by a Non-Participating Provider or Non-Plan Provider for which you are responsible after benefits have been provided (except for the cost difference between the Hospital's rate for a


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private room and a semi-private room).

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

1. Charges that exceed the Eligible Charge or Maximum Allowance.
2. The Coinsurance resulting from Covered Services you may receive from a Participating Provider.
3. Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Behavioral Health Unit.
4. Services, supplies, or charges limited or excluded in this Certificate.
5. Expenses not covered because a benefit maximum if any has been reached.

If you have Family Coverage, each member of your family must satisfy the out-of-pocket expense limit.

When there is no out-of-pocket expense limit for Non-Participating Providers, as set forth in the Benefit Highlights section of this Certificate, you will continue to be responsible for any Deductible, Coinsurance Amount and/or Copayment Amount for Covered Services received from Non-Participating Providers.

**This out-of-pocket expense limit amount is subject to change or increase as permitted by applicable law or regulatory guidance.**

**EXTENSION OF BENEFITS IN CASE OF TERMINATION**

If you are Totally Disabled at the time your entire Group terminates, benefits will be provided for, and limited to, the Covered Services described under this Certificate, which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's policy due to the absence of coverage in the policy. Benefits will be provided for a period of no more than 12 months from the date of termination. It is your responsibility to notify Blue Cross and Blue Shield, and to provide, when requested by Blue Cross and Blue Shield, written documentation of such disability.

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

**CONTINUITY OF CARE**

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

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

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than ninety (90) days from the date of the notice to the covered person of the Provider's disaffiliation from the Network, or


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if the covered person has entered the second or third trimester of pregnancy at the time of the Provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery.

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

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

You have the right to appeal any decision made for a request for benefits under this provision as explained in the **CLAIM APPEALS PROCEDURES** provision in the **HOW TO FILE A CLAIM** section.


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# PEDIATRIC VISION CARE

Coverage for **PEDIATRIC VISION CARE** is made part of and is in addition to any information you may have in your Blue Cross and Blue Shield Certificate. Coverage for **PEDIATRIC VISION CARE** provides information about coverage for the routine vision care services outlined below, which are specifically excluded under your medical/surgical health care plan. (Services that are covered under your medical/surgical Certificate are not covered under this **PEDIATRIC VISION CARE** benefit.) All provisions in the medical Certificate apply to coverage for **PEDIATRIC VISION CARE** unless specifically indicated otherwise below.

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

**DEFINITIONS**

**Benefit Period**

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

**Provider**

For purposes of **PEDIATRIC VISION CARE***,* a licensed Ophthalmologist or Optometrist operating within the scope of their license, or a dispensing optician operating within the scope of their license.

**Participating Vision Provider**

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

**Non-Participating Vision Provider**

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

**Vision Materials**

Corrective lenses and/or frames or contact lenses.

**Eligibility**

Children who are covered under a Blue Cross and Blue Shield medical/surgical plan, up to age 19, are eligible for coverage for **PEDIATRIC VISION CARE**.

**NOTE:** Once coverage is lost under the medical/surgical plan, all benefits cease for **PEDIATRIC VISION CARE**. Extension of benefits due to disability, state or federal continuation coverage, and conversion option privileges are not available for **PEDIATRIC VISION CARE**.

**Limitations and Exclusions**

In addition to the general limitations and exclusions listed in your medical/surgical certificate, **PEDIATRIC VISION CARE** does not cover services or materials connected with or charges arising from:

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
2. Aniseikonic spectacle lenses.
3. Medical and/or surgical treatment of the eye, eyes, or supporting structures.
4. Plano (non-prescription) lenses and/or contact lenses.


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5. Non-prescription sunglasses (except for discount);
6. Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order.
7. Services or materials provided by any other group benefit plan providing vision care.
8. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.
9. Any vision service, treatment or materials not specifically listed as a Covered Service.
10. Services and materials that are Experimental or Investigational or materials which are rendered prior to your effective date.
11. Services and materials incurred after the termination date of your coverage unless otherwise indicated.
12. Services and materials not meeting accepted standards of optometric practice.
13. Services and materials resulting from your failure to comply with professionally prescribed treatment.
14. Telephone consultations.
15. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
16. Office infection control charges.
17. Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts.
18. State or territorial taxes on vision services performed.
19. Medical treatment of eye disease or injury.
20. Visual therapy.
21. Special lens designs or coatings other than those described in this brochure.
22. Two pairs of eyeglasses in lieu of bifocals.
23. Services not performed by licensed personnel.
24. Prosthetic devices and services.
25. Insurance of contact lenses; and
26. Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother, or sister, by blood, marriage, or adoption.

**How the Vision Care Plan Works**

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

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

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

Questions about services covered under the vision care plan, Participating Vision Providers, or about benefits provided or denied under the plan can be directed to EyeMed seven days a week, Monday through Saturday 6:30 A.M. to 10:00 P.M., and Sunday 10:00 A.M. to 7:00 P.M. (Central Time) at 1-844-684-2254. An Interactive Voice Response unit is also available


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outside normal business operating hours. (Please direct member enrollment, termination, and other subscriber or Dependent eligibility questions to Blue Cross and Blue Shield of Illinois-not to EyeMed.) Members using a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services through calling or using a TTY machine to engage an operator at 711 and asking the operator to call EyeMed at 1-844-230-6498. Customer service hours and operations are subject to change without notice.

If you obtain glasses or contacts from a Non-Participating Vision Provider, you must pay the Provider in full and submit a claim for reimbursement (see **HOW TO FILE A CLAIM** for more information).

You may receive your eye examination and eyeglasses/contacts on different dates or through different provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Provider. Continuity of care will best be maintained when all available services are obtained at one time from one Participating Vision Provider and there may be additional professional charges if you seek contact lenses from a Provider other than the one who performed your eye examination.

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


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## HOSPICE CARE PROGRAM

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

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

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

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

1. Durable medical equipment.
2. Home delivered meals.
3. Homemaker services.
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition; and
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.

**Benefit Payment for Hospice Care Program Services**

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


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# OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. Benefits will not be provided for any self-administered drugs dispensed by a Physician. This Benefit Section of your 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, your benefits for drugs and supplies will be greater when you obtain them from a Preferred Participating Pharmacy Provider. You can visit the Blue Cross and Blue Shield website at www.bcbsil.com for a list of Participating Pharmacy Providers or call the customer service toll-free number on your identification card. The Pharmacies that are Preferred Participating Pharmacy Provider, Participating Pharmacy Providers, Preferred Specialty Pharmacy Providers may change from time to time. 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, Preferred or Specialty in modifying a Pharmacy shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Pharmacy. In addition, the omission, non-use or non-designation of Participating or any similar modifier or the use of a term such as Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Pharmacy.

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

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

**BRAND NAME DRUG** – means a drug or product manufactured by a single manufacturer as defined by a nationally recognized Provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name (Preferred) or (Non-Preferred) Drug. There may also be situations where a drug's classification changes from Generic to 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 Brand Name (Preferred or Non-Preferred).

**BRAND NAME DRUG (Non-preferred)** – means a Brand Name Drug that is identified on the *Drug List*. The *Drug List* is accessible by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

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

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

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

**COPAYMENT AMOUNT** – means the dollar amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy Provider or Non-Participating Pharmacy Provider.

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

1. Which is Medically Necessary and is ordered by a Health Care Practitioner naming you as the recipient.


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2. For which a written or verbal Prescription Order is provided by a Health Care Practitioner.

3. For which a separate charge is customarily made.

4. Which is not consumed or administered at the time and place that the Prescription Order is written.

5. For which the FDA has given approval for at least one indication; and

6. Which is dispensed by a Pharmacy and is received by you while covered under this Benefit Section, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the EXCLUSIONS provision later in this Benefit Section).

**DRUG LIST** – means a list of all drugs that may be covered under this OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS SECTION and related services section of this Certificate. A current list is available on our Web site at https://www.bcbsil.com/prescription-drugs/managing-prescriptions/drug-lists. You may also contact a Customer Service Representative at the telephone number shown on the back of your Identification Card for more information.

**ELIGIBLE CHARGE** – means (a) in the case of a Provider which has a written agreement with a Blue Cross and Blue Shield Plan, or with the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with a Blue Cross and Blue Shield Plan, or with the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

1. The charge which the particular Prescription Drug Provider usually charges for Covered Services, or

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

**GENERIC DRUG** – means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding payment level, Blue Cross and Blue Shield utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information. Generic Drugs are listed on the *Drug List* which is available on the Blue Cross and Blue Shield website at www.bcbsil.com. You may also contact a customer service advocate for more information.

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

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

**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 acting within the scope of their license.

**LEGEND DRUGS** – means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

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

**NON-PARTICIPATING PHARMACY PROVIDER OR NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER –** has the meaning set forth in the DEFINITIONS SECTION of this Certificate.

**PARTICIPATING PHARMACY PROVIDER OR PARTICIPATING PRESCRIPTION DRUG PROVIDER** – has the meaning set forth in the DEFINITIONS SECTION of this Certificate.

**PHARMACY** – has the meaning set forth in the DEFINITIONS SECTION of this Certificate.


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**PREFERRED PARTICIPATING PHARMACY PROVIDER** – means a Participating Pharmacy Provider which has a written agreement with Blue Cross and Blue Shield to provide pharmaceutical services to you or an entity chosen by Blue Cross and Blue Shield to administer its prescription drug program that has been designated as a Preferred Pharmacy Provider.

**PREFERRED SPECIALTY PHARMACY PROVIDER** – means a Participating Prescription Drug Provider that has a written agreement with Blue Cross and Blue Shield, or with the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide Specialty and Complex Care Drugs to you.

**PRESCRIPTION ORDER** – means a written or verbal order from a Health Care Practitioner to a pharmacist for a drug to be dispensed. Orders written by a Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under this Benefit Section.

**SPECIALTY AND COMPLEX CARE DRUGS** – means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected but may also include drugs that are high-cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty and Complex Care Drugs is subject to change. To determine which drugs are Specialty and Complex Care Drugs, refer to the *Drug List* by accessing the Blue Cross and Blue Shield website at www.bcbsil.com or call the customer service toll-free number on your identification card.

**SPECIALTY AND COMPLEX CARE DRUGS (Non-preferred)** – means a Specialty and Complex Care Drug, which may be a Generic or Brand Name Drug, that is identified on the *Drug List* as a Specialty and Complex Care Drug (Non-Preferred). The *Drug List* is available by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

**SPECIALTY AND COMPLEX CARE DRUGS (preferred)** – means a Specialty and Complex Care Drug, which may be a Generic (Preferred) or Brand Name Drug, that is identified on the *Drug List* as a Preferred Specialty and Complex Care Drug. The *Drug List* is available by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

**ABOUT YOUR BENEFITS**

**Drug List**

Drugs listed on the Drug List are selected by Blue Cross and Blue Shield based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with Blue Cross and Blue Shield. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the Drug List. Entire drug classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List.

Positive changes (e.g., adding drugs to the Drug List or drugs moving to a lower payment tier) occur quarterly after review by the committee. Changes to the Drug List that could have an adverse financial impact to you (i.e., drug exclusion, drug moving to a higher payment tier, or drugs requiring Prior Authorization) occur quarterly or annually. However, when there has been a pharmaceutical manufacturer recall or other safety concern, changes to the Drug List may occur more frequently.

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

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

If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug your prescriber or may be able to ask for an expedited review process by marking the


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review as an urgent request. Blue Cross and Blue Shield will let you, your prescriber, or authorized representative know the coverage decision within 24 hours after they receive your request for an expedited review. If the coverage request is denied, Blue Cross and Blue Shield will let you, your prescriber, or your authorized representative know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals and external exception review process you will receive with the denial determination. Call the number on the back of your identification card if you have any questions.

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 and Complex Care Drugs, as applicable.

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

**Prior Authorization**

When certain medications and drug classes, such as medications used to treat rheumatoid arthritis, growth hormone deficiency, and hepatitis C are prescribed, your Physician will be required to obtain authorization from Blue Cross and Blue Shield in order for your medication to be eligible for benefits. Medications included in this program are subject to change and other medications for other conditions may be added to the program. Although you may currently be on therapy, your claim may need to be reviewed to see if the criteria for coverage of further treatment has been met.

Blue Cross and Blue Shield or its prescription drug administrator will send a questionnaire to your Physician upon your or your Pharmacy's request. The questionnaire must be returned to the prescription drug administrator who will review the questionnaire and determine whether the reason for the prescription meets the criteria for Medically Necessary care. You and your Physician will be notified of the prescription drug administrator's determination. Coverage will only be provided for Medically Necessary care. Although you are not required to obtain authorization prior to purchasing the medication, you are strongly encouraged to do so, to help you and your doctor factor your cost into your treatment decision. If criteria for Medical Necessity is not met, coverage will be denied, and you will be responsible for the full charge incurred.

To find out more about Prior Authorization requirements or to determine which drugs or drug classes require Prior Authorization, you should refer to the *Drug List* by accessing the Blue Cross and Blue Shield website at www.bcbsil.com or call the customer service toll-free number on your identification card. Please see the "*Drug List"* provision for more information about changes to the programs.

**Dispensing Limits**

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, coverage will only be provided for a clinically appropriate pre-determined maximum quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

The maximum quantity of a given prescription drug means the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. However, benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained. To determine if a specific drug is subject to this limitation, you can refer to the *Drug List* by accessing the Blue Cross and Blue Shield website at www.bcbsil.com or call the customer service toll-free number on your identification card.

If you require a Prescription Order in excess of the dispensing limit established by Blue Cross and Blue Shield, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. Dispensing limits may change from time to time. Payment for benefits covered under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

**Controlled Substances Limitation**

If it is determined that you may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess


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whether Medically Necessary and appropriate and coverage restrictions, which may include but not limited to limiting coverage to services provided by a certain Provider and/or Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. For the purpose of this provision, controlled substance medications are medications classified or restricted by state or federal laws. Coinsurance Amount and/or Copayment Amount and any Deductible may apply.

**Day Supply**

In order to be eligible for coverage under this benefit section, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation described in this benefit section. Benefits under this benefit section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Some drugs covered under your plan may be subject to certain supply/fill limitations pursuant to diagnoses or new-to-therapy requirements, plan design, and/or state or federal regulations. For specific drug supply/fill information, please call the customer service toll-free number located on your identification card. Coverage for Specialty and Complex Care Drugs are limited to a 30-day supply. However, some Specialty and Complex Care 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. However, early prescription refills of a covered 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.

**Multi-Category Split Fill Program**

If this is your first time using select medications (e.g., cancer medications) or if a medication that has not been filled within 120 days, the Member may only be eligible for a partial fill (14 – 15-day supply) of the medication for up to the first three months of therapy. This is to help see how the medication is working for you. If you receive partial fill, your Copayment and/or Coinsurance after your deductible will be adjusted to align with the quantity of medication dispensed. If the medication is working for you and your Physician wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit the https://www.bcbsil.com/prescription-drugs/pharmacies/programs website. Please be advised these lists are subject to change without notice.

**Prenatal Vitamins**

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

**Extended Prescription Drug Supply Program**

Your coverage includes benefits for up to a 90-day supply of maintenance type drugs and diabetic supplies purchased from a Preferred Participating Prescription Drug Provider (which may only include retail or home delivery pharmacies). However, you may receive coverage for up to a 12-month supply for dispensed contraceptive drugs and products that are covered under the Outpatient Prescription Drug Program benefit section. Benefit payment amounts are listed in the Benefit Highlight Section. The payment levels described in the Benefit Highlights of this Certificate are for a 30-day supply. To find a list of Pharmacies participating in this program, refer to the Blue Cross and Blue Shield website at www.bcbsil.com.

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

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

**Prescription Refills**


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

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

When necessary to permit synchronization, the Plan will prorate the Copayment Amount or Coinsurance Amount, on a daily basis, due for Covered Drugs based on the proportion of days the reduced Prescription Order covers to the regular day supply as shown on the Benefit Highlights in this Certificate.

**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 the following for treatment of the indication for which the drug is prescribed to treat you for a chronic, disabling, or life-threatening illness:
    a. A prescription drug reference compendium, or
    b. Substantially accepted peer-reviewed medical literature.

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

Some prescription drug products may be more cost-effective than others. In some instances, you and your Physician may be contacted by your Pharmacy about switching to an alternative drug. The Pharmacy may not provide a substitute drug without your Physician's and your approval. Please refer to the provision titled "Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers" in the **GENERAL PROVISIONS** section of this Certificate.

A separate Copayment Amount or Coinsurance 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. Cost-sharing requirements for a twin-pack of Medically Necessary epinephrine injectors will not exceed $60, when obtained from a Participating Pharmacy Provider. Benefits will not be provided under this benefit section for any self-administered drugs dispensed by a Physician.

**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 Provider , after your program deductible has been met.


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**Immunosuppressant Drugs**

Benefits are available for Medically Necessary immunosuppressant drugs with a written prescription after an approved Human Organ Transplant. If your Physician indicates “may not substitute” on a Covered prescribed immunosuppressant drug, BCBSIL will not require a pharmacist to interchange another immunosuppressant drug.

**Pregnancy Tests**

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

**Fertility Drugs**

Benefits are available for Medically Necessary fertility drugs in connection with the diagnosis and/or treatment of Infertility with a written prescription.

**Therapies to Treat Menopause**

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

**Alzheimer’s Disease and Related Dementias**

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

**Contraceptive Drugs**

Benefits are available for contraceptive drugs and products shown on the *Contraceptive Coverage List* and will not be subject to any Deductible, Coinsurance Amount and/or Copayment Amount when received from a Participating Pharmacy Provider. You may access the Blue Cross and Blue Shield website at www.bcbsil.com for more information.

**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 Provider.

**Diabetic Supplies for Treatment of Diabetes**

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

1. Test strips specified for use with a corresponding blood glucose monitor.
2. Glucose test solutions.
3. Glucagon.
4. Glucose tablets.
5. Lancets and lancet devices.
6. Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein Insulin and insulin analog preparations.
7. Injection aids, including devices used to assist with insulin injection and needleless systems.
8. Insulin syringes.
9. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels.
10. Glucagon emergency kits; and


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11. Biohazard disposable containers.

**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 Provider, and for follow-up services, when obtained from a Participating Provider, after your program Deductible has been met.

**HIV Post-Exposure Prophylaxis**

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

**Long-term Antibiotic Therapy**

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

Oral antibiotics will be covered under 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.

**Testing, Screening, Vaccinations, and Treatment obtained through Pharmacies.** Benefits for vaccinations are available through certain Participating Pharmacy Providers that have contracted with Blue Cross and Blue Shield to provide this service. To locate one of these contracting Participating Pharmacy Providers in your area and to find out which vaccinations are covered, call the customer service toll-free number on your identification card or access the website at www.bcbsil.com. At the time you receive services, present your Blue Cross and Blue Shield identification card to the pharmacist. This will identify you as a participant in the Blue Cross and Blue Shield health care plan provided by your employer. The pharmacist will inform you of the amount for which you are responsible for, if any.

Each Participating Pharmacy Provider that has contracted with Blue Cross and Blue Shield to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this Benefit Section. Refer to your Blue Cross and Blue Shield medical coverage for benefits available for childhood immunizations.

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

Vaccinations that are received from a Non-Participating Provider, a Non-Plan Provider facility, or a Non-Participating Pharmacy Provider or other routine Covered Services not provided for under this provision may be subject to the Deductible, Coinsurance Amount, Copayment Amounts and/or benefit maximum.

**Specialty and Complex Care Drugs**

Benefits are available for Specialty and Complex Care Drugs as described under Specialty and Complex Care Pharmacy Program.

**Self-Administered Cancer Medications**

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


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**Cancer Medications**

Benefits will be provided for orally administered cancer medications, or self-injected cancer medications that are used to treat cancer when a particular legend drug has been shown effective for the treatment of that specific type of cancer and if proper documentation is provided, even though that legend drug may not have FDA-approval for that type of cancer. The drug must have been shown to be effective for the treatment of that particular cancer according to the American Hospital Formulary Service Drug Information; National Comprehensive Cancer Network's Drugs & Biologics Compendium; Thomson Micromedex's Drug Dex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services. After your deductible has been met, your Copayment Amount, or Coinsurance Amount will not apply to orally administered cancer medications when received from a Participating Pharmacy Provider. Coverage of prescribed orally administered cancer medications when received from a non-Preferred Specialty Pharmacy Provider or Non-Participating Pharmacy Provider will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

**Stage 4 Advanced Metastatic Cancer**

Coverage for an FDA-approved drug used to treat Stage 4 advanced metastatic cancer will not be limited or excluded by requiring a Member to first fail to successfully respond to a different drug or prove a history of failure of a different drug, as long as the use of the prescribed drug is consistent with best practices for the treatment of Stage 4 advanced metastatic cancer and is supported by peer-reviewed medical literature."

**Opioid Antagonists**

Benefits will be provided for at least one opioid antagonist drug, including the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the opioid antagonist. This includes refills for expired or utilized opioid antagonists.

**NOTE:** Benefits for naloxone hydrochloride, will be provided at no charge, when obtained from a Participating Pharmacy Provider, after your program Deductible has been met.

**Opioid Medically Assisted Treatment**

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

**Intranasal Opioid Reversal Agent**

Benefits will be provided for at least one intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50 MME or higher.

**NOTE:** Benefits for naloxone hydrochloride, will be provided at no charge, when obtained from a Participating Pharmacy Provider, after your program Deductible has been met.

**Prescription Topical Medications**

Benefits will be provided for prescription topical eye medication, and early prescription refills may be available for covered prescription topical eye medications used to treat a chronic condition of the eye after at least 75% of the predicted days of use, and if the early refills requested do not exceed the total number of refills prescribed by the prescribing Physician or Optometrist.

Benefits will also be provided for prescription topical anti-inflammatory medication, including but not limited to Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain.

**SELECTING A PHARMACY**

**Participating Pharmacy Provider**

When you choose to go to a Participating Pharmacy Provider:

1. Present your identification card to the pharmacist along with your Prescription Order.


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2. Provide the pharmacist with the birth date and relationship of the patient.

3. Pay the applicable Deductible, if any; and

4. Pay the appropriate Copayment Amount or Coinsurance Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

The amount Participating Pharmacy Providers have agreed to accept as payment in full is the lesser of:

1. The Billed Charges; or

2. The Eligible Charge; or

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

**The level of benefits paid will be the highest level available under this Certificate when pharmaceutical services are received from a Preferred Participating Pharmacy Provider.**

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

If you are unsure whether a Pharmacy is a Participating Pharmacy Provider, you may access the Blue Cross and Blue Shield website at www.bcbsil.com or call the customer service toll-free number on your identification card.

**Non-Participating Pharmacy Provider**

If you choose to have a Prescription Order filled or obtain a covered vaccination at a Non-Participating Pharmacy Provider, you must pay the Pharmacy the full amount of its bill and submit a Claim form to Blue Cross and Blue Shield or to the prescription drug administrator with itemized receipts verifying that the Prescription Order was filled, or a covered vaccination was provided.

Please refer to the provision titled “Filing Outpatient Prescription Drug Claims” in the **HOW TO FILE A CLAIM** section of this Certificate.

**Home Delivery Prescription Drug Program**

The Home Delivery Prescription Drug Program provides delivery of Covered Drugs directly to your home address. In addition to the benefits described in this Benefit Section, your coverage includes benefits for Maintenance Drugs and diabetic supplies obtained through the Home Delivery Prescription Drug Program.

Some drugs may not be available through the Home Delivery Prescription Drug Program. For a listing of Maintenance Drugs or if you have any questions about the Home Delivery Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the home delivery order form, you may access the Blue Cross and Blue Shield website at www.bcbsil.com or call the customer service toll-free number on your identification card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

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

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

For information about the Home Delivery Prescription Drug Program, call the customer service toll-free number on your identification card.

**Specialty and Complex Care Pharmacy Program**

This program provides delivery of medications directly to your Health Care Practitioner, administration location or to your home if you are undergoing treatment for a complex medical condition. To determine which drugs are Specialty and Complex

Care Drugs, you should refer to the Prescription Drug Section on the Plan's website at https://www.bcbsil.com/il/documents/rx-drugs/specialty-drug-list-il.pdf

or call the customer service toll-free number on your identification card.

In order to receive maximum benefits for Specialty and Complex Care Drugs, you must obtain the Specialty and Complex Care Drugs from a preferred Specialty Pharmacy Provider. When you obtain Specialty and Complex Care Drugs from a preferred Specialty Pharmacy Provider, benefits will be provided according to the payment provisions indicated in this Benefit Highlights of this Certificate.

"Coverage for Specialty and Complex Care Drugs are limited to a 30-day supply. However, some Specialty and Complex Care Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your plan benefits. Cost-share will be based on the day supply dispensed. (1-30 day supply; 31-60 day supply; 61-90 day supply)."

**MedsYourWay™**

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

The amount you pay for your Prescription will be applied, if applicable, to your Deductible and out-of-pocket maximum. Available select Covered Drugs and drug discount card pricing through MedsYourWay may change occasionally but your cost with available select covered drugs through MedsYourWay will never be higher than the listed cost share on the schedule for the specific tier the drug is listed under. Certain restrictions may apply, and certain Covered Drugs or drug 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.

MedsYourWay may not be available in all states or pharmacies and will be operated only to the extent permitted by law.

**YOUR COST**

**Deductible**

If you are responsible for a Coinsurance Amount, each Benefit Period you must satisfy the Participating Provider program Deductible described in the Benefit Highlights of this Certificate for your medical benefits before your benefits will begin for drugs and diabetic supplies.

If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on your behalf, that amount will not be applied to your program deductible or out-of-pocket expense limit until you have met the minimum annual deductible for HDHP-HSA plans, pursuant to federal law. Once this deductible has been met, then third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on your behalf will apply to any remaining out-of-pocket expense limits.

**Out-of-Pocket Expense Limit**

Expenses incurred by you for Covered Drugs and diabetic supplies received from a Preferred Participating Pharmacy Provider, Participating Pharmacy Provider or Preferred Specialty Pharmacy Provider will be applied towards the Participating Provider out-of- pocket expense limit as indicated in the Benefit Highlights section of this Certificate.

Expenses incurred by you for Covered Drugs and diabetic supplies received from a Non-Participating Pharmacy Provider or non- preferred Specialty Pharmacy Provider will be applied towards the Non-Participating Provider out-of-pocket expense as indicated in the Benefit Highlights section of this Certificate. When there is no out-of-pocket expense limit for Non-


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Participating Pharmacy Providers and non-Preferred Specialty Pharmacy Providers as set forth on the Schedule Page of this Certificate, you will continue to be responsible for any Deductible, Coinsurance Amount and/or Copayment Amount for Covered Drugs received from Non-Participating Pharmacy Providers or non-Preferred Specialty Pharmacy Providers.

If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on your behalf, that amount will not be applied to your program deductible or out-of-pocket expense limit until you have met the minimum annual deductible for HDHP-HSA plans, pursuant to federal law. Once this deductible has been met, then third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on your behalf will apply to any remaining out-of-pocket expense limits.

**BENEFIT PAYMENT FOR PRESCRIPTION DRUGS**

**How Member Payment is Determined**

The amount that you are responsible for is based upon the drug tiers as described below and shown on the Benefit Highlights of this Certificate.

- Tier 1 – includes mostly Generic Drugs (preferred) and may contain some Brand Name Drugs.
- Tier 2 - includes mostly Generic Drugs (Non-preferred) and may contain some Brand Name Drugs.
- Tier 3 – includes mostly Brand Name Drugs (preferred) and may contain some Generic Drugs.
- Tier 4 – includes mostly Brand Name Drugs (Non-preferred) and may contain some Generic Drugs.
- Tier 5 – includes mostly Specialty and Complex Care Drugs (preferred) and may contain some Generic Drugs.
- Tier 6 – includes mostly Specialty and Complex Care Drugs (Non-preferred) and may contain some Generic Drugs.

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 Provider.

If you or your Provider request a brand name drug when a generic drug is available, you will pay the applicable Copayment Amount and/or Coinsurance based on current tier of brand name drug plus the difference between the allowable amount of the brand name drug and the allowable amount of the generic drug, except as otherwise provided in this certificate. Any “differences” between the cost of the Generic Drug and the cost of the Brand Name Drug will apply to the deductible or out-of-pocket maximum.

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 use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment Amount and/or Co-Share Amounts will still apply. For additional information, visit the Blue Cross and Blue Shield website at www.bcbsil.com and log in to Blue Access for Members℠ (BAM) or call the number on the back of your identification card. Benefits will be provided as shown on the Benefit Highlights of this Certificate.

**Retail Pharmacy**

The benefits you receive and the amount you pay will differ depending upon the type of drugs, or diabetic supplies or insulin and insulin syringes obtained and whether they are obtained from a Preferred Participating, Participating or Non-Participating Pharmacy Provider.

When you obtain Covered Drugs (other than Specialty and Complex Care Drugs), including diabetic supplies from a Preferred Participating or Participating Pharmacy Provider, benefits will be provided as shown in the Benefit Highlights section of this Certificate.

When you obtain Covered Drugs, including diabetic supplies from a Non-Participating Pharmacy Provider (other than a Participating Pharmacy Provider), benefits will be provided at 50% of the amount you would have received had you obtained drugs from a Participating Pharmacy Provider minus the Deductible, if any, If an out-of-pocket expense limit is shown on the Benefit Highlights of this Certificate for Non-Participating Pharmacy Providers, then the Copayment Amount and


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Coinsurance Amount will apply towards the out-of-pocket expense limit if any for Non-Participating Pharmacy Providers. However, none of your other expenses at such Non-Participating Pharmacy Providers will apply towards the out-of-pocket expense limit.

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

One prescription means up to a 30 consecutive day supply of a drug. Certain drugs may be limited to less than a 30 consecutive day supply.

In addition, up to a 90-day supply of certain drugs may be obtained through the Extended Prescription Drug Supply Program.

However, you may receive coverage for up to a 12-month supply for oral contraceptives.

For additional information on these drugs, call the customer service toll-free number on your identification card.

**Home Delivery Prescription Drug Program**

When you obtain Covered Drugs through the Home Delivery Prescription Drug Program, benefits will be provided as shown in the Benefit Highlights section of this Certificate.

Under the Home Delivery Prescription Drug Program, one prescription means up to a 90 consecutive day supply of a drug. Coverage for certain drugs may be limited to less than a 90 consecutive day supply.

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

However, you may receive coverage for up to a 12-month supply for dispensed contraceptives.

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

**Specialty and Complex Care Pharmacy Program**

When you obtain covered Specialty and Complex Care Drugs from a non-Preferred Specialty Pharmacy Provider, benefits will be provided at 50% of the amount you would have received had you obtained drugs from a Preferred Specialty Pharmacy Provider minus the Copayment Amount or Coinsurance Amount and your share of the cost will not apply to your Deductible. If an out-of-pocket expense limit is shown on the Benefit Highlight of this Certificate for Non-Participating Pharmacy Providers, then only your Copayment Amount or Coinsurance Amount will apply to the out-of-pocket expense limit. Any additional charge will not be applied to your out-of-pocket expense limit.

**EXCLUSIONS**

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

1. Administration or injection of any drugs.
2. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Vaccinations administered through certain Participating Pharmacy Providers are an exception to this exclusion.
3. Athletic performance enhancement drugs.
4. Benefits will not be provided for any self-administered drugs under this benefit section dispensed by a Physician.
5. Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.
6. Bulk Powders.
7. Certain drug classes where there are no over- the-counter alternatives available.
8. Compound Drugs.
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.


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10. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
11. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies). However, coverage for prescription contraceptive devices and the rental or purchase of a manual electric or Hospital grade breast pump may be provided under the medical portion (Preventive Care Services provision) of this Certificate.
12. Devices, Technologies, and/or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, therapeutic devices, artificial appliance, "digital health technologies and/or applications," or similar devices (except disposable hypodermic needles and syringes for self-administered injections).
13. Diagnostic agents (except for diabetic testing supplies or test strips).
14. Drugs 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.
15. Drugs determined to have inferior efficacy or significant safety issues.
16. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed in excess of the amount or beyond the time period allowed by law.
17. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
18. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
19. Drugs which are not included on the Drug List, unless specifically covered elsewhere in this Policy and/or such coverage is required in accordance with applicable law or regulatory guidance.
20. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
21. Drugs, that the use or intended use of which would be illegal, abusive, or not Medically Necessary.
22. Drugs to treat sexual dysfunction.
23. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted.
24. Drugs which are repackaged by a company other than the original manufacturer.
25. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and vaccinations administered through certain Participating Pharmacy Provider); and drugs or covered devices for which no valid Prescription Order is obtained.
26. 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.
27. Institutional packs and drugs which are repackaged by anyone other than the original manufacturer.
28. Medications in depot or long-acting formulations that are intended for use longer than the covered days supply amount.


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29. 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.
30. Non-FDA approved Drugs.
31. 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.
32. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined.
33. 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.
34. 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.
35. Certain prescription drugs administered by a health care professional may not be covered under the medical benefit, including those newly approved by the FDA, those approved through the FDA's accelerated approval program, or if there is a self-administered formulation of the drug available. For additional information, see the "Medical Drug Benefit Program" provision.
36. Vitamins (except prenatal vitamins when prescribed by a Physician or Advanced Practice Nurse, and those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).


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# EXCLUSIONS—WHAT IS NOT COVERED

Expenses for the following are not covered under your Benefit Program:

**Hospitalization, or health care services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not Medically Necessary. Medically Necessary means that a specific medical, health care, supply or Hospital service is required, for the treatment or management of a medical symptom or condition and that the service, supply, or care provided is the most efficient and economical service which can safely be provided.

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

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

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

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's initial decision, your Certificate provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so as described in the **HOW TO FILE A CLAIM** section of this Certificate.

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

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


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b. Services in connection with providing the non-covered service.

c. Hospitalization required to perform the non-covered service; or

d. Services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

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

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

In most instances the decision whether hospitalization or other health care services or supplies were Medically Necessary will be made **AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED**.

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

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's decision, your Policy provides for an appeal of that decision. You must exercise your right to appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so within 180 days after you have been notified that your Claim has been denied by writing to:

Claim Review Section
Blue Cross and Blue Shield
P.O. Box 660603
Dallas, TX 75266-0603

You may furnish or submit additional documentation which you or your Physician believe appropriate.

**REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, OR APPROVES HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES, DOES NOT MEAN THAT THEY WILL BE MEDICALLY NECESSARY AS DEFINED IN THIS CERTIFICATE AND IS NOT A GUARANTEE OF BENEFITS**.

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

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

3. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received (except in the case of Medicare),except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

4. Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act


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of war.

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

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

7. 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.

8. Custodial Care Service.

9. Long Term Care Service.

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

11. Inpatient Private DutyNursing Service.

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

13. However, this exclusion does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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

15. 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 similarcoverage.

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

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

18. Special braces, specialized equipment, appliances, ambulatory apparatus, except as specifically mentioned in this Certificate.

19. Services or supplies for:

    - Intersegmental traction.
    - all types of home traction devices and equipment.
    - vertebral axial decompression sessions.
    - surface EMGs.
    - spinal manipulation under anesthesia.
    - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
    - balance testing through computerized dynamic post urography sensory organization test.

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

21. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye which are not Medically Necessary, except for Pediatric

Vision and as specifically mentioned in this Certificate.

22. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
23. Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet rich plasma.
24. Treatment of tissue damage or disease in any location with platelet rich plasma.
25. Immunizations, unless otherwise specified in this Certificate.
26. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate.
27. Maintenance Care.
28. Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability, or mental disability, except as may be provided under this Certificate for Autism Spectrum Disorder(s).
29. Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services, except as they relate to Autism Spectrum Disorder(s).
30. Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group, and each is covered separately under this Certificate.
31. Diagnostic Service as part of premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Experimental/Investigational unless otherwise specified in this Certificate.
32. Reversal of vasectomies.
33. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
34. Wigs (also referred to as scalp prostheses), unless otherwise specified in this Certificate.
35. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.
36. Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.
37. Testing of:
    - blood for measurement of levels of: Lipoprotein a; small dense low-density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels.
    - urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover.
    - cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes).
    - allergen specific IgG measurement.
38. Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.
39. Acupuncture, whether for medical or anesthesia purposes, dry needling, or trigger-point acupuncture.
40. Notwithstanding any provision in the Certificate to the contrary, any services and/or supplies provided to you outside the United States, unless you receive Emergency Accident Care or Emergency Medical Care.

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

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

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

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

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

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

- services with a primary diagnosis that is not Autism Spectrum Disorder.
- services that are facilitated by a Provider that is not properly credentialed. Please see the definition of "Qualified ABA Provider" in the **DEFINITIONS SECTION** of this Certificate, Activities primarily of an education nature.
- shadow or companion services.
- any program or service performed in nonconventional setting (even if the services are performed by a Qualified ABA Provider), including spas/resorts; wilderness camp or ranch programs; academic, vocational, or recreational settings.
- any other services not provided by an appropriately licensed Behavioral Health Practitioner in accordance with nationally accepted treatment standards; or
- more than one Qualified ABA Provider providing similar services on the same day(s).

Some laboratory services are not covered by your Plan. The following laboratory services are not covered:

1. Allergen Testing:

    a. Routine re-testing for confirmed allergies to the same allergies except in children and adolescents with positive food allergen results to monitor for food allergy resolution; or
    b. The Antigen Leukocyte Antibody test (ALCAT); or
    c. In-vitro testing of allergen specific IgG or non-specific IgG, IgA, IgM, and/or IgD in the evaluation of suspected allergy; or
    d. Basophil Activation flow cytometry testing for measuring hypersensitivity to allergens; or
    e. In-vitro allergen testing using bead-based epitope assays; or
    f. In-vitro testing of allergen non-specific IgE;

2. Cardiovascular Disease Risk Assessment Testing:

    g. High-sensitivity C-Reactive Protein except when a risk-based treatment decision is not certain after having a quantitative risk assessment using American College of Cardiology/American Heart Association (ACC/AHA) calculator to calculate 10-year risk of Cardiovascular disease CVD; or
    h. High-sensitivity C-Reactive Protein as a screening test for the general population or for monitoring response to therapy; or


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i. High-sensitivity cardiac troponin T for cardiovascular risk assessment and stratification in the outpatient setting; or
j. Homocysteine testing for cardiovascular disease risk assessment screening, evaluation, and management; or
k. Novel Cardiovascular Biomarkers such as measurement of novel lipid and non-lipid biomarkers as an add on to LDL cholesterol in the risk assessment of cardiovascular disease; or
l. Cardiovascular risk panels, consisting of multiple individual biomarkers intended to assess cardiac risk (other than simple lipid panels); or
m. Serum Intermediate Density Lipoprotein as an indicator of cardiovascular disease risk; or
n. Measurement of lipoprotein-associated phospholipase as an indicator of risk of cardiovascular disease; or
o. Measurement of secretory type II phospholipase in the assessment of cardiovascular risk for all indications; or
p. Measurement of long-chain omega-3 fatty acids in red blood cell membranes, including but not limited to its use as a cardiac risk factor; or
q. All other tests for assessing cardiovascular health disease risk.

3. Cervical Cancer Screening:

r. Cervical cancer screening and testing for HPV more than one time per calendar year when:
    i. Testing for high-risk strains of HPV-16 and HPV-18 unless both cytology negative and HPV positive co-testing criteria are present; or
    ii. Testing on individuals that have no history of cervical cancer or pre-cancer and that do not have a uterus and cervix; or
    iii. Inclusion of low-risk strains of HPV in co-testing; or
s. Other technologies are used for cervical cancer screening.

4. Drug testing: Except where testing is rendered in an urgent/emergency situation or as a component of routine physical/medical exam or related to surgery or medical care, drug testing is not covered in an outpatient setting in the following situations:

t. Testing to confirm the presence and/or amount of drugs in your system when laboratory-based definitive drug testing is requested without any prior screening test results, or when laboratory-based definitive drug testing is requested for larger than seven drug class panels: or
u. Use of proprietary drug tests such as CareView360; or
v. Specific validity testing, including, but not limited to urine specific gravity, urine creatinine, Ph, urine oxidant level, and genetic identify testing are included in the panel test – these tests will not be covered if submitted individually and when a urine panel test was also ordered at the same time; or
w. Testing for any American Medical Association definitive drug class codes; or
x. Same-day testing for the same drug or metabolites from two different samples (e.g., both a blood and a urine specimen); or
y. Testing of samples with abnormal validity tests; or
z. Drug testing for patients in a facility setting (inpatient or outpatient) are not separately covered, as they are included in the daily charge at the facility; or Both qualitative (type of drug) testing and presumptive (verification of presents of drugs) testing on the same specimen.

5. Folate Testing:
a. Measurement of red blood cell (RBC) folate; or
b. Measurement of serum folate concentration unless the individual has been diagnosed with megaloblastic or macrocytic anemia and those conditions do not resolve after folic acid treatment; or
c. Folate receptor autoantibody testing.

6. Hemoglobin A1c: Hemoglobin A1c testing in the following situations:


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a. If an individual has had a blood transfusion in the last 120 days: or
b. If an individual has a condition associated with increased red blood cell turnover; or
c. If an individual is also being measured for fructosamine;

7. Iron Homeostasis and Metabolism:
   a. Ferritin or transferrin measurement, including transferrin saturation, as a screening test in asymptomatic individuals; or
   b. Serum hepcidin testing, including immunoassays; or
   c. GlycA testing to measure or monitor transferrin or other glycosylated proteins.

8. Pancreatic Enzyme Testing:
   a. As part of an ongoing assessment of therapy for acute pancreatitis; or
   b. To determine the prognosis of pancreatitis; or
   c. To determine the severity or progression of pancreatitis; or
   d. More than once per visit; or
   e. For the diagnosis, prognosis, or severity of chronic pancreatitis; or
   f. As part of an ongoing assessment or therapy of chronic pancreatitis; or
   g. In asymptomatic nonpregnant individuals during general exam without abnormal findings; or
   h. Measurement of serum or urine trypsin/trypsinogen/TAP (trypsinogen activation peptide) for the diagnosis, assessment, prognosis and/or determination of severity of acute pancreatitis; or
   i. For the diagnosis, assessment, prognosis, and/or determination of severity of acute pancreatitis, measurement of the following biomarkers is not covered:
      i) C-Reactive Protein (CRP); or
      ii) Interleukin-6 (IL-6); or
      iii) Interleukin-8 (IL-8); or
      iv) Procalcitonin; or
   j. Measurement of urinary amylase concentration for the initial diagnosis of acute pancreatitis for individuals presenting with signs and symptoms of acute pancreatitis.

9. Thyroid Disease:
   a. Testing of reverse T3, T3 uptake and total T4 in individuals with no signs or symptoms consistent with hypothyroidism and who are not at high risk for thyroid disease; or
   b. Measurement of total T3 (TT3) and/or free T3 (fT3) for the assessment of hypothyroidism; or
   c. Measurement of total or free T3 level to assess levothyroxine in hypothyroid individuals; or
   d. Testing in asymptomatic nonpregnant individuals for thyroid dysfunction during a general exam without abnormal findings.

10. Vitamin B12:
   a. Testing or screening for a Vitamin B12 deficiency in a healthy, asymptomatic individual; or
   b. Homocysteine or holotranscobalamin testing to screen for or to confirm a Vitamin B12 deficiency; or
   c. Vitamin B12 testing within three (3) months of beginning treatment for a B12 deficiency.

11. Vitamin D: Routine screening for Vitamin D deficiency with serum testing in asymptomatic individuals and/or during general encounters.


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# COORDINATION OF BENEFITS SECTION

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

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

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but
2. May be reduced when, under the order of benefit 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 Programs covering the person for whom the claim is made.

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

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

BENEFIT PROGRAM – means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

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

Each contract or other arrangement under (1) or (2) above is a separate benefit program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate 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


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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 are 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., parent):

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

   b. If both parents have the same birthday, the benefits of the 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 custody of the child; and

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

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

4. Dependent Child if Parents Share Joint Custody

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

5. Young Adult as a Dependent

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

6. Active or Inactive Employee

The benefits of neither a Benefit Program that covers a person as an employee who is neither laid-off nor retired (or as that employee's Dependent) are determined before those of a Benefit Program that covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of benefits, this rule shall not apply.

7. Continuation Coverage

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

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

   b. Second, the benefits under the continuation coverage.

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

8. Length of Coverage

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

**WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM**

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

The benefits of this Benefit Program will be reduced when 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. Blue Cross and Blue Shield has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Benefit Program must give Blue Cross and Blue Shield 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, Blue Cross and Blue Shield may pay that amount to the organization that made the payment under the other Benefit Program. That amount will then be treated as though it were a benefit paid under this Benefit Program. Blue Cross and Blue Shield will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

**RIGHT OF RECOVERY**

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


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

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


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# CONTINUATION OF COVERAGE AFTER TERMINATION

**(Illinois State Laws)**

**This CONTINUATION OF COVERAGE AFTER TERMINATION section does not apply to Domestic Partners and their children.**

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the Eligible Person (see definitions) at the time of termination. The provisions described in Article B will apply if you are the spouse of or the party to a Civil Union with a retired Eligible Person and at least 55 years of age or former spouse of or the former party to a Civil Union with a retired Eligible Person who has died or from whom you have been divorced or no longer party to a Civil Union. 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 of 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, Surgical-Medical and/or Major Medical coverage provided under this Certificate for themselves and their eligible dependents (if they had Family Coverage on the date of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation of 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 of coverage will not be available to you if: (a) you are covered by Medicare, except if you have been covered under a group Medicare supplement policy, 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.

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 of 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 Blue Cross and Blue Shield for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to Blue Cross and Blue Shield (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.

5. Continuation of coverage under this Certificate will end on the date you become eligible for Medicare 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 of coverage under this Certificate will also end on the first to occur of the following:

    a. The date 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.


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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 of coverage period. When your continuation of coverage period has expired, the provisions of this Certificate titled **EXTENSION OF BENEFITS IN CASE OF TERMINATION** (when applicable) will apply to you.

**ARTICLE B: Continuation of 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 themself and their eligible dependents (if Family Coverage is in effect at the time of termination). However, this continuation of 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 Blue Cross and Blue Shield 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, Blue Cross and Blue Shield 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. Blue Cross and Blue Shield'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 of 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 Blue Cross and Blue Shield.

3. In the event you fail to provide written notice to Blue Cross and Blue Shield 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 of coverage will then be forfeited.

4. If Blue Cross and Blue Shield 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 Blue Cross and Blue Shield'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 Blue Cross and Blue Shield as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

1. 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.

2. Termination of Continuation of Coverage:

   If you have not reached age 55 at the time your continued coverage begins, your continuation of 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 into 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.

3. If you have reached age 55 at the time your continued coverage begins, your continuation of 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.

4. If you exercise the right to continuation of 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.

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

**ARTICLE C: Continuation of 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 themself. However, this continuation of 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 of coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the Eligible Person with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.


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3. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to Blue Cross and Blue Shield 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, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield'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 of 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 Blue Cross and Blue Shield.

4. In the event you, or the responsible adult acting on your behalf as the Dependent child, fail to provide written notice to Blue Cross and Blue Shield 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 of coverage will then be forfeited.

5. If Blue Cross and Blue Shield 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 Blue Cross and Blue Shield'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 Blue Cross and Blue Shield as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

1. Continuation of 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. The expiration of 2 years from the date your continued coverage under this Certificate began.

2. If you exercise the right to continuation of 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.

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


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## CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

The purpose of this section 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 of 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 of 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 OF COVERAGE AFTER TERMINATION (Illinois State Laws)** section and the **CONTINUATION COVERAGE RIGHTS UNDER COBRA** section of this Certificate.

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


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## CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

The purpose of this section 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 Domestic Partner of an Eligible Person or as the Dependent child of a Domestic Partner. Your continued coverage under this Certificate will be provided only as specified below. Please read the provisions very carefully.

**NOTE:** Domestic Partner coverage is available at your Employer's discretion. Contact your Employer for information on whether Domestic Partner coverage is available for your Group.

**Continuation of Coverage**

If you are the Domestic Partner or the Dependent child of a Domestic Partner and you lose coverage under this Certificate, you have the same options as the spouse or Dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a Dependent child are described in the **CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws)** section and the **CONTINUATION COVERAGE RIGHTS UNDER COBRA** section, if applicable to your Group.

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

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


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# CONTINUATION COVERAGE RIGHTS UNDER COBRA

This **CONTINUATION COVERAGE RIGHTS UNDER COBRA** section does not apply to your Dependent who is your Domestic Partner and their children.

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

**Introduction**

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

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

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

**What Is COBRA Continuation Coverage?**

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

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

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

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

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

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

1. The parent-employee dies.
2. The parent-employee's hours of employment are reduced.
3. The parent-employee's employment ends for any reason other than their gross misconduct.
4. The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both).
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "Dependent child."


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

**When Is COBRA Coverage Available?**

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

**You Must Give Notice of Some Qualifying Events**

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

**How Is COBRA Coverage Provided?**

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

COBRA continuation coverage is a temporary continuation of 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 employees' hours of employment, and the employee becomes 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 their employment terminates, COBRA continuation coverage for their 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 employees' 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 60$^{th}$ 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.


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**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.


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## CONTINUATION COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

**NOTE: The CONTINUATION COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES** applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Public employees and surviving spouses or surviving parties to a Civil Union of such employees who are eligible for continued group health coverage under Sections 367 (g), (h) and (i) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The public employee, surviving spouse or surviving party to a Civil Union must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such employee, spouse or party to a Civil Union has Family Coverage, they may continue to have Family Coverage.

2. Group coverage can be continued until the public employee, surviving spouse or surviving party to a Civil Union is no longer eligible, as specified in Sections 367 (g), (h) and (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for Dependent children). Coverage for a surviving spouse or surviving party to a Civil Union will end if such spouse or surviving party to a Civil Union should remarry or enter another Civil Union. It is the employee/spouse's or surviving party to a Civil Union's responsibility to inform the Plan of their loss of eligibility.

3. The total monthly premium for this continuation coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the public employee, surviving spouse or surviving party to a Civil Union.


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## CONTINUATION COVERAGE FOR 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, they 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 their 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.


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## CONTINUATION COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES

**NOTE: The CONTINUATION COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES** applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

If you are a full-time law enforcement, correctional or correctional probation officer, or firefighter and are eligible for continued group health insurance under the Public Safety Employee Benefits Act (820 ILCS 320), you may maintain such group health insurance under the following conditions:

1. You and your eligible Dependents must have been insured under this Certificate on the day immediately preceding the date of eligibility for continued group health insurance.
2. Your Group shall pay the entire premium of the group health insurance coverage for you, your spouse, your party to a Civil Union and each Dependent child until the child reaches the limiting age under this Certificate or until the end of the calendar year in which the child reaches the limiting age under this Certificate, whichever is later.
3. If you subsequently die, your Group shall continue to pay the entire health insurance premium for your surviving spouse or your surviving party to a Civil Union until he or she remarries or enters another Civil Union and for your Dependent children under the conditions established in 2. above.
4. Health insurance benefits under this Certificate shall be reduced by health insurance benefits payable from any other source.


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# PEDIATRIC DENTAL BENEFIT SECTION

## COVERED SERVICES

The Benefits of this section are subject to all the terms and conditions of your Contract. Benefits are available only for services and supplies that are "Medically Necessary", unless otherwise specified. All Covered Services listed in this section are subject to the *Exclusions and Limitations* section of this Certificate, which lists services, supplies, situations or related expenses that are not covered.

**It is important for you to refer to your *Benefit Highlights* to find out what your Deductible, Benefit Period Maximums and Out-of-Pocket Limits will be for a Covered Service. If you do not have a *Benefit Highlights*, please call a customer service Representative at the number shown on your Identification Card.**

Your Dental benefits include coverage for the following Covered Services as long as these services are rendered to you by a Physician or a Dentist. When the term "Dentist" is used in this Certificate, it will mean Physician or Dentist.

### Diagnostic Evaluations

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

1. Periodic oral evaluations for established patients.
2. Problem focused oral evaluations, whether limited, detailed or extensive.
3. Comprehensive oral evaluations for new or established patients.
4. Comprehensive periodontal evaluations for new or established patients.
5. Oral evaluations of children under the age of three, including counseling with primary caregiver.
6. Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every Benefit Period in the dental office.

Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months.

Benefits will not be provided for comprehensive periodontal evaluations or problem focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.

Benefits will not be provided for tests and oral pathology procedures, or for reevaluations.

### Preventive Services

Preventive services are performed to prevent dental disease. Covered Services include:

1. Prophylaxis—Professional cleaning, scaling, and polishing of the teeth. Benefits will be limited to two cleanings every 12 months.
2. Topical Fluoride Application—Benefits for Fluoride Application is only available to Eligible Person under age 19 and are limited to two applications every 12 months.

### Special Provisions Regarding Preventive Services

1. Cleanings include associated scaling and polishing procedures.
2. Following active periodontal treatment, benefits are available for a combination of two prophylaxes and two periodontal maintenance treatments (see "Non-Surgical Periodontic Services") every 12 months.

### Diagnostic Radiographs

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

1. Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 36 months.
2. Bitewing films – Benefits are limited to four horizontal films or eight vertical films once every 12 months.
3. Intraoral periapical films, as necessary for diagnosis – Benefits are limited to six every 12 months.


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Benefits will not be provided for any radiographs taken related to the diagnosis with Temporomandibular Joint (TMJ) Dysfunction.

**Miscellaneous Preventive Services**

Miscellaneous preventive services are other services performed to prevent dental disease and include:

1. Sealants—Benefits for sealants are limited to one per permanent molar per lifetime and are available to an Eligible Person under age 19.
2. Space Maintainers—Benefits for space maintainers are limited to a lifetime maximum of one appliance per missing tooth site for Subscribers up to age 19.

Benefits are not available for nutritional, Tobacco or oral hygiene counseling.

**Basic Restorative Dental Services**

Basic Restorative services are restorations necessary to repair dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Covered Services include:

1. Amalgams restorations—Benefits are limited to one per surface per tooth surface every 12 months.
2. Sedative fillings.
3. Resin-based composite restorations—Benefits are limited to one per surface per tooth surface every 12 months.

**Non-Surgical Extractions**

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

1. Removal of retained coronal remnants—deciduous tooth.
2. Removal of erupted tooth.

**Non-Surgical Periodontal Services**

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

1. Periodontal scaling and root planing—Benefits are limited to one per quadrant every 24 months. Additional scaling in the presence of generalized moderate to severe gingival inflammation is limited to once every 6 months combined with prophylaxes and periodontal maintenance.
2. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once per lifetime.
3. Periodontal maintenance procedures—Benefits are limited to two every 12 months in combination with routine oral prophylaxis and must be performed following active periodontal treatment.

**Adjunctive Services**

Adjunctive general services include:

1. Palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment.
2. Deep sedation/general anesthesia and intravenous sedation/non-intravenous conscious sedation—by report only and when determined to be Medically Necessary for documented persons with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Medical Necessity.
3. Nitrous Oxide analgesia will be covered for Eligible persons under age 19.
4. Therapeutic parenteral Drug Injections will be covered for Eligible persons under age 19. Benefits will not be provided for local anesthesia or other drugs or medicaments and/or their application.

**Endodontic Services**

Endodontics is the treatment of dental disease of the tooth pulp and includes:

1. Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure.
2. These services are considered part of the root canal procedure if root canal therapy is performed within 45 days of


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services.

3. Root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.

4. Apexification/recalcification procedures and apicoectomy/periarticular services including surgery, retrograde filling, root amputations and hemi section.

Benefits will not be provided for the following Endodontic Services:

1. Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist on the same tooth.

2. Pulp vitality tests, endodontic endosseous implants, intentional reimplantation, canal preparation, fitting of performed dowel and post, or post removal.

3. Endodontic therapy if you discontinue endodontic treatment.

**Oral Surgery Services**

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

1. Surgical tooth extraction.

2. Alveoloplasty and ventriculoplasty;

3. Excision of benign odontogenic tumor/cysts.

4. Excision of bone tissue.

5. Incision and drainage of an intraoral abscess; and

6. Other Medically Necessary surgical and repair procedures not specifically excluded in this Certificate.

Intraoral soft tissue and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered part of the procedure.

Benefits will not be provided for the following Oral Surgery procedures:

1. Surgical services related to a congenital malformation.

2. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.

3. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and 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 bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; reduction of dislocation, or excision of the temporomandibular joints.

**Surgical Periodontal Services**

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and include:

1. Gingivectomy or genioplasty and gingival flap procedures (including root planning)—Benefits are limited to one quadrant every 24 months.

2. Clinical crown lengthening.

3. Osseous surgery, including flap entry and closure—Benefits are limited to one per quadrant every 24 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.

4. Osseous grafts—Benefits are limited to one per site every 24 months. Benefits are not available for bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.


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5. Soft tissue grafts/allografts (including donor site)—Benefits are limited to one per site every 24 months.

6. Distal or proximal wedge procedure.

Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores, or basic restorations are considered part of the restoration.

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

**Major Restorative Services**

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

1. Single crown restorations.

2. Inlay/onlay restorations.

3. Labial veneer restorations.

Benefits will not be provided for the replacement of a lost, missing, or stolen appliance or for replacement or appliances that have been damaged due to abuse, misuse, or neglect.

Benefits will not be provided to alter, restore, or correct vertical dimension of occlusion. Such procedures may include, but are not limited to equilibration dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.

Benefits will not be provided for the restoration of occlusion on incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 months, even if the original crown was stainless steel.

**Prosthodontic Services**

Prosthodontics involve procedures necessary for providing artificial replacements for missing natural teeth and includes:

1. Complete (upper and lower dentures) and removable partial dentures (upper and lower dentures)—Benefits will be provided for the initial installation of removable complete, immediate, or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 60-month period. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement, or loss.

2. Denture reline/rebase procedures—Benefits will be limited to one procedure in a 24 month period after the initial 6 month period following initial placement.

3. Fixed bridgework (fixed prosthetics)—Benefits will be provided for the initial installation of a bridgework, including inlays/onlays and crowns.

4. Benefits will be limited to once every 60 months.

5. Maxillofacial Prosthetics.

6. Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

**NOTE:** An implant is a covered procedure of the plan only if determined to be Medically Necessary. Claim review for implant services are conducted by licensed Dentists who review the clinical documentation submitted by your treating Dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefit will be allowed for the individual implant or implant procedure. Only the second phase of treatment (the prosthodontic phase-placement of the implant crown, bridge, or partial denture) may be subject to the alternate benefit provision of the plan.

1. Implant retained crowns, bridges, and dentures are subject to the alternate benefit provision of the plan.

2. Endosteal, eposteal, and transosteal implants-one every 60 months only if determined to be Medically Necessary.

3. Benefits will not be provided for the following Prosthodontic Services.

4. Treatment to replace teeth which were missing prior to the Coverage Date.

5. Congenitally missing teeth.

6. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.


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**Miscellaneous Restorative and Prosthodontic Services**

Other restorative and prosthodontics services include:

1. Prefabricated crowns—Benefits for stainless steel and resin-based crowns are limited to one per tooth every 60 months. These crowns are not intended to be used as temporary crowns.
2. Recementation of inlays/onlays, crowns, bridges, and post and core—Benefits will be limited to two recementations every 12 months. However, any recementation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.
3. Core buildup, post and core, and prefabricated post and core are limited to 1 per tooth every 60 months.
4. Crown and bridge repair services.
5. Pulp cap—direct and indirect.
6. Prosthodontic service adjustments—Benefits will be limited to three times per appliance every 12 months.
7. Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp.

**Medically Necessary Orthodontic Dental Services**

Benefits for Medically Necessary orthodontic services are limited to Eligible Persons who meet the Plan criteria related to a medical condition such as:

1. Cleft palate or other congenital craniofacial malformations requiring reconstructive surgical correction in addition to orthodontic services.
2. Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services.
3. Skeletal anomaly involving maxillary and/or mandibular structures. Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

Benefits for Medically Necessary orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth. Your Covered Services for orthodontics are shown on your ***Benefit Highlights***. Covered services include:

1. Diagnostic orthodontic records and radiographs limited to a **lifetime maximum of once per person**.
2. Limited, interceptive, and comprehensive orthodontic treatment.
3. Orthodontic retention, limited to a lifetime maximum of one appliance per person.

**Special Provisions Regarding Orthodontic Services:**

1. Pediatric Orthodontic Services—Coverage is limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion) or meeting or exceeding a score of 42 from the Modified Salzmann Index.
2. Orthodontic services are paid over the Course of Treatment, up to the maximum Benefit Period orthodontic Benefit. Benefits cease when you are no longer covered, whether or not the entire Benefit has been paid out.
3. Orthodontic treatment is started on the date the bands or appliances are inserted.
4. Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic benefit and subject to the Benefit Period maximum for orthodontic services.
5. If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
6. If your coverage is terminated prior to the completion of the orthodontic treatment plan, the Insured is responsible for the remaining balance of treatment costs.
7. Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Subscriber is not covered.


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8. Benefits are not available for replacement or repair of an orthodontic appliance.

9. For services in progress on the Coverage Date, benefits will be reduced based on the benefits paid prior to this coverage beginning.

**Implant Placement Surgery**

Covered Services include the surgical placement, maintenance, and repair of an implant body, including services associated with preparation of the implant site (e.g., splinting, grafting).


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# PEDIATRIC DENTAL EXCLUSIONS AND LIMITATIONS

These general ***Exclusions and Limitations*** apply to all services described under the Pediatric Dental section of this Certificate. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (as defined in the ***Definitions*** section) licensed to perform services covered under this Certificate.

**IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS**

**Dental Procedures Which Are Not Medically Necessary**

**Please note that in order to provide you with dental care Benefits at a reasonable cost, the Plan provides benefits only for those Covered Services for eligible dental treatment that are determined to be Medically Necessary.**

No benefits will be provided for procedures which are not Medically Necessary. Medically Necessary generally means that a specific procedure provided to you is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you.

The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

**Care By More Than One Dentist**

If you change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

**Alternate Benefits**

In all cases in which there is more than one Course of Treatment or service to treat an Eligible Person dental condition, the benefit will be based on the least costly covered service or Course of Treatment.

When two or more services are submitted and the services are considered part of the same service, the Plan will pay the most comprehensive service as determined by the Plan.

When two or more services are submitted on the same day and the services are considered mutually exclusive (one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by the Plan.

If you and your Dentist or Physician decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the Benefit for the least costly course of treatment procedures for dental services.

**Non-Compliance with Prescribed Care**

Any additional treatment and resulting liability which is caused by the lack of your cooperation with the Dentist or from noncompliance with prescribed dental care will be your responsibility.

**EXCLUSIONS - WHAT IS NOT COVERED**

No Benefits will be provided under this section of this Plan for:

1. Amounts which are in excess of the Maximum Allowance.
2. Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a Claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
3. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received (except in the case of Medicare), except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, benefits provided


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in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

4. Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth, lack of tooth enamel and grafts to improve aesthetics except as described in the pediatric Medically Necessary orthodontic benefit as shown in ***Medically Necessary Orthodontic Dental Services*** subsection of the **PEDIATRIC DENTAL CARE BENEFIT SECTION**.
5. Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Certificate.
6. Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders or to increase vertical dimension.
7. Dental services which are performed due to an accidental injury, except for persons under age 19. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury.
8. Services and supplies for any illness or injury suffered after your Coverage Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
9. Services or supplies that do not meet accepted standards of dental practice.
10. Experimental, Investigational and/or services and supplies and all related services and supplies.
11. Hospital and ancillary charges.
12. 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.
13. Services or supplies for which “discounts” or waiver of deductible or Coinsurance Amounts are offered.
14. Services rendered by a Dentist related to you by blood or marriage.
15. Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
16. Claims for services which are for the same services performed on the same date for the same Eligible Person.
17. Services or supplies received for behavior management or consultation purposes.
18. Charges for nutritional, Tobacco or oral hygiene counseling.
19. Charges for local, state, or territorial taxes on dental services or procedures.
20. Charges for the administration of infection control procedures as required by local, state, or federal mandates.
21. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary, or provisional appliances.
22. Charges for telephone consultations, email, or other electronic consultations, missed appointments, completion of a Claim form or forwarding requested records or x-rays.
23. Charges for prescription or nonprescription mouthwashes, irrigation, mouth rinses, topical solutions, preparations, or medicament carriers.
24. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
25. Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
26. Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your Coverage Date under this Plan; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after your Effective Date.
27. Charges for occlusion analysis diagnostic casts or occlusal adjustments.


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28. Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
29. Case presentations or detailed and extensive treatment planning when billed for separately.
30. Orthodontic treatment that is not Medically Necessary.
31. Gold foil restorations.
32. Cone beam imaging and cone beam MRI procedures.
33. Sealants for teeth other than permanent molars.
34. Localized delivery of antimicrobial agents or chemotherapeutic agents.
35. Comprehensive periodontal evaluations or problem focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.
36. Tests and oral pathology procedures, or for reevaluations.
37. Any radiographs taken related to the diagnosis of Temporomandibular joint (TMJ) Dysfunction.
38. Local anesthetic or other drugs or medicaments and/or their application.
39. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of performed dowel and post, or post removal.
40. Endodontic therapy if you discontinue endodontic treatment.
41. Surgical services related to a congenital malformation.
42. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
43. Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
44. The replacement of a lost, missing, or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
45. To alter, restore, or correct vertical dimension of occlusion. Such procedures may include, but are not limited to equilibration dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.
46. The restoration of occlusion on incisal edges due to bruxism or harmful habits.
47. Treatment to replace teeth which were missing prior to the Coverage Date.
48. Congenitally missing teeth.
49. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
50. Replacement or repair of an orthodontic appliance.
51. 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.
52. Services or supplies for:
    - Intersegmental traction.
    - all types of home traction devices and equipment.
    - vertebral axial decompression sessions.
    - surface FMGs.
    - spinal manipulation under anesthesia.


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- muscle testing through computerized kinesiology machines such as Isolation, Digital Myograph and Dynatron; and
- balance testing through computerized dynamic post urography sensory organization test.

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

54. Testing of:

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

The Plan may, without waiving these exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the exclusions listed above. If it is later determined that the care and services are excluded from your coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under the Pan. You must provide the Plan with all documents it needs to enforce its rights under this provision.

# HOW TO FILE A CLAIM

In order to obtain your benefits under this Certificate, it is necessary for a Claim to be filed with Blue Cross and Blue Shield. To file a Claim, usually all you will have to do is show your Blue Cross and Blue Shield identification card to your Hospital or Physician (or other Provider) when you receive services. They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

Once Blue Cross and Blue Shield receives your Claim, it will be processed, and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases, Blue Cross and Blue Shield will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Group Administrator or from your local Blue Cross and Blue Shield office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

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

In any case, Claims should be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Group Administrator or call your local Blue Cross and Blue Shield office.

**FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS**

In certain situations, you will have to file your own Claims in order to obtain benefits for Outpatient prescription drugs. This is primarily true when you did not receive an identification card, the Pharmacy was unable to transmit a Claim, or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a prescription drug Claim Form. These forms are available from your Group Administrator or from your local Blue Cross and Blue Shield office.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

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

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

**INITIAL CLAIMS DETERMINATIONS**

Blue Cross and Blue Shield will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day


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after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. Blue Cross and Blue Shield will usually notify you, your valid assignee, or your authorized representative when all information required to process a Claim in accordance with the terms of the benefit program within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this Certificate).

**If a Claim Is Denied or Not Paid in Full**

If the Claim for benefits is denied you or your authorized representative shall be notified in writing of the following:

1. The reasons for determination.
2. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination.
3. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary.
4. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.
5. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal. Specifically, this explanation will include:
    a. An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);
    b. An explanation that you may ask for an external review with an Independent Review Organization (IRO) not associated with Blue Cross and Blue Shield and if your appeal was denied based on any of the reasons below. You may also ask for external review if Blue Cross and Blue Shield failed to give you a timely decision (see 4. below), and your Claim was denied for one of these reasons.
        i. A decision about the medical need for or the experimental status of a recommended treatment.
        ii. Your health care coverage was rescinded. For additional information, see the definition of "Rescission" in the **DEFINITIONS SECTION** of this Certificate.

        To ask for an external review, complete the request for External Review form that will be provided to you and available at https://idoi.illinois.gov/consumers/file-an-external-review.html and submit it to the Department of Insurance at the address shown below for external reviews.
    c. An explanation that you may ask for an expedited (urgent) external review if:
        i. Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health, or ability to regain maximum function.
        ii. Blue Cross and Blue Shield failed to give you a decision within 48 hours of your request for an expedited appeal; or
        iii. The request for treatment is experimental or investigational and your health care Provider states in writing that the treatment would be much less effective if not promptly started.
    d. If the written notice is for a Final Adverse Determination, the notice will include an explanation that you may ask for an expedited (urgent) external review if the Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.
    e. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield sends you a written decision for appeals that need medical review within 15 business days after we receive any needed

information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. Decisions on expedited appeals are considered timely if Blue Cross and Blue Shield sends you a written decision within 48 hours of your request for an expedited appeal.

6. In certain situations, a statement in non-English language(s) that written notices of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);

7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield.

8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits.

9. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request.

10. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on Medical Necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request.

11. In the case of a denial of an Urgent Care Clinical claim a description of the expedited review procedure applicable to such claims. An Urgent Care Clinical claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification.

The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman.

For complaints and general inquiries:

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

Illinois Department of Insurance
Office of Consumer Health Insurance
115 South LaSalle Street
13th Floor
Chicago, Illinois 60603
(312) 814-2420

For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
4th Floor
320 West Washington
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

## INQUIRIES AND COMPLAINTS

An **"Inquiry"** is a general request for information regarding, Claims, benefits, or membership. A **"Complaint"** is an expression of dissatisfaction by you either orally or in writing.

Blue Cross and Blue Shield has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to the following:

1. Claims.
2. Quality of care.

When your Complaint relates to dissatisfaction with a Claim denial (or partial denial), then you have the right to a claim review/appeal as described in the **CLAIM APPEAL PROCEDURES**.

To pursue an Inquiry or 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 Street
Chicago, Illinois 60601-5099

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

### Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are three types of claims as defined below.

1. **Urgent Care Clinical Claim** is any pre-service claim that requires Prior Authorization, as described in this Benefit booklet, for benefit 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 of Treatment.
2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. **Claim, also known as Post-Service Claim,** is notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information with Blue Cross and Blue Shield may request in connection with services rendered to you.


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**Urgent Care Clinical Claims***

| Type of Notice or Extension | Timing |
|---|---|
| If your claim is incomplete, Blue Cross and Blue Shield must notify you within: | 24 hours** |
| If you are notified that your claim is incomplete, you must then provide completed claim information to Blue Cross and Blue Shield within: | 48 hours after receiving notice |
| Blue Cross and Blue Shield must notify you of the claim determination (whether adverse or not): | |
| If the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than: | 72 hours |
| After receiving the completed claim (if the initial claim is incomplete), within: | 48 hours |

* You do not need to submit Urgent Care Clinical Claims in writing. You should call Blue Cross and Blue Shield at the toll-Free number listed on the back of your identification card as soon as possible to 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, Blue Cross and Blue Shield must notify you within: | 5 days* |
| If your claim is incomplete, Blue Cross and Blue Shield must notify you within: | 15 days |
| If you are notified that your claim is incomplete, you must then provide completed claim information to blue Cross and Blue Shield within: | 45 days after receiving notice |
| *Blue Cross and Blue Shield must notify you of the claim determination (whether adverse or not):* | |
| If the initial claim is complete, within | 15 days** |
| After receiving the completed claim (if the initial claim is incomplete), within: | 30 days |
| If you require post-stabilization care after and Emergency within: | The time appropriate to the circumstance not to exceed one hour after the time of request |

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

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


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**Post-Service Claims**

| Type of Notice or Extension | Timing |
|---|---|
| If your claim is incomplete, Blue Cross and Blue Shield must notify you within: | 30 days |
| If you are notified that your claim is incomplete, you must then provide completed claim information to Blue Cross and Blue Shield within: | 45 days after receiving notice |
| *Blue Cross and Blue Shield must notify you of any adverse claim determination:* | |
| If the initial claim is complete, within: | 30 days* |
| After receiving the completed claim (if the initial claim is incomplete), within: | 45 days |

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

**Concurrent Care**

For benefit determination 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, in response to a Claim, pre-service Claim or Urgent Care Clinical Claim, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an Ongoing Course of Treatment had been approved by Blue Cross and Blue Shield and Blue Cross and Blue Shield reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission is also an Adverse Benefit Determination.

In addition, an **Adverse Benefit Determination**, also includes an "Adverse Determination." An "Adverse Determination" means:

1. A determination by Blue Cross and Blue Shield or its designee utilization review organization that, based upon the information provided, a request for a benefit under Blue Cross and Blue Shield's health benefit plan upon application of any utilization review technique does not meet Blue Cross and Blue Shield's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit; or
2. A rescission of coverage determination. For additional information, see the definition of "Rescission" in the **DEFINITIONS SECTION** of this Certificate.

**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 a 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 and an opportunity to appeal. For the Ongoing Course of Treatment, coverage will continue during the appeal process.


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Upon receipt of an expedited pre-service or concurrent clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Blue Cross and Blue Shield will render a decision on the appeal within 24 hours after it receives the requested information, but in no event more than 48 hours after the appeal has been received by Blue Cross and Blue Shield.

**How to Appeal an Adverse Benefit Determination**

You have the right to seek and obtain a review of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made by Blue Cross and Blue Shield in accordance with the benefits and procedures detailed in your Health Benefit Plan.

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

If you believe Blue Cross and Blue Shield incorrectly denied all or part of your benefits, you may have your claim reviewed. Blue Cross and Blue Shield will review its decision in accordance with the following procedure:

1. Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to Blue Cross and Blue Shield to request a claim review. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the Adverse Benefit Determination.
2. In support of your claim review, you have the option of presenting evidence and testimony to Blue Cross and Blue Shield. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments, and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.
3. To contact Blue Cross and Blue Shield to request a Claim review or appeal an Adverse Benefit Determination, use the following contact information:

Claim Review Section
Blue Cross and Blue Shield
P.O. Box 660603
Dallas, TX 75266-0603
1-800-538-8833 Toll-free number
1-888-235-2936 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), Blue Cross and Blue Shield will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by Blue Cross and Blue Shield in connection with the appealed claim, as well as any new or additional rationale for a denial at the internal appeals stage.

Such new or additional evidence or rationale 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. Blue Cross and Blue Shield 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 on medical judgment, the appeal will be conducted by individuals associated with Blue Cross and Blue Shield and/or external advisors, but who were not involved in making the initial denial of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by Blue Cross and Blue Shield (except in situations where you are not required to exhaust the appeals process).


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**Timing of Non-Urgent Appeal Determinations**

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

Blue Cross and Blue Shield will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 15 business days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 15 business days after we receive any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've alreadyreceived the service.

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

**Notice of Appeal Determination**

Blue Cross and Blue Shield will notify the party filing the appeal, you, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal.

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

1. The reasons for thedetermination.
2. A reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for thedetermination.
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with the meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.
4. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final decision on internal appeal. Specifically, this explanation will include:
    a. An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);
    b. An explanation that you may ask for an external review with an Independent Review Organization (IRO) not associated with Blue Cross and Blue Shield and if your appeal was denied based on any of the reasons below. You may also ask for external review if Blue Cross and Blue Shield failed to give you a timely decision (see 4. below), and your claim was denied for one of these reasons.
        **i.** A decision about the medical need for or the experimental status of a recommended treatment. Your health care coverage was rescinded. For additional information see the definition of "Rescission" in the **DEFINITIONS SECTION** of this Certificate.

        To ask for an external review, complete the request for External Review form that will be provided to you and available at insurance.illinois.gov/external review and submit it to the Department of Insurance at the address shown below for external reviews.
    c. An explanation that you may ask for an expedited (urgent) external review if:
        i. Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health, or ability to regain maximum function.
        ii. Blue Cross and Blue Shield failed to give you a decision within 48 hours of your request for an expedited appeal; or
        iii. The request for treatment is experimental or investigational and your health care Provider states in

writing that the treatment would be much less effective if not promptly started; and

iv. The Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

d. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield sends you a written decision for appeals that need medical review within 15 business days after we receive any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. Decisions on expedited appeals are considered timely if Blue Cross and Blue Shield sends you a written decision within 48 hours of your request for an expedited appeal.

5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative.

6. In certain situations, a statement in non-English language(s) that written notices of claim denials and certain other benefit information may be available (upon request) in such non-English language(s).

7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield.

8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits.

9. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request.

10. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request.

11. A description of the standard that was used in denying the claim and a discussion of the decision.

12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on their own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review.

13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review.

14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and file an external review regardless of the status of a Provider appeal.

15. The number of levels of appeals 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; and

16. A Request for External Review Form, Authorized Representative Form, (HCP) Health Care Provider Certification Request for Expedited Review Form, and (HCP) Health Care Provider Certification Experimental/Investigational Review Form.

The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For complaints and general inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, IL 62767
(877) 527-9431 Toll-free phone


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

(217) 558-2083 Fax number
DOI.Complaints@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Illinois Department of Insurance
Office of Consumer Health Insurance
115 South LaSalle Street
13th Floor
Chicago, Illinois 60603
(312) 814-2420

For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington
4TH Floor
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

If Blue Cross and Blue Shield's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **INDEPENDENT EXTERNAL REVIEW** section below.

You may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify Blue Cross and Blue Shield of the Complaint. Blue Cross and Blue Shield will have 21 days to respond to the Illinois Department of Insurance.

The operations of Blue Cross and Blue Shield are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

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, IL 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
DOI.Complaints@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Illinois Department of Insurance
Office of Consumer Health Insurance
115 South LaSalle Street
13th Floor
Chicago, Illinois 60603
(312) 814-2420

You must exercise the right to internal appeal as a precondition to taking any action against Blue Cross and Blue Shield, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

**Forum Selection**

In the event of any dispute relating to or arising from this Plan, the jurisdiction and venue for the dispute is the United States District Court for the Northern District of Illinois. If, and only if, the United States District Court for the Northern District of Illinois lacks subject-matter jurisdiction over such dispute, the jurisdiction and venue for the dispute is the Circuit Court of Cook County, Illinois.

**If You Need Assistance**

If you have any questions about the claims procedures or the review procedure, write or call Blue Cross and Blue Shield at 1-800-538-8833. Blue Cross and Blue Shield offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday.

Blue Cross and Blue Shield of Illinois
P.O. Box 660603
Dallas, TX 75266-0603
1-800-538-8833 Toll-free phone

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431 or call the number on the back of your identification card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

**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 Blue Cross and Blue Shield or its designated utilization review organization, at the completion of Blue Cross and Blue Shield's internal grievance process procedures.

1. **Standard External Review**

You or your authorized representative must submit a written request for a standard external independent review to the Illinois Department of Insurance ("IDOI") within four months of receiving an Adverse Determination or Final Adverse Determination. Your request should be submitted to the IDOI at the following address:

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

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

2. **Preliminary Review.** Within five business days of receipt of the request from the IDOI, Blue Cross and Blue Shield will complete a preliminary review of your request to determine whether:

   a. You were a covered person at the time health care service was requested or provided;

   b. The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this Certificate, but Blue Cross and Blue Shield has determined that the health care service is not covered;

   c. You have exhausted Blue Cross and Blue Shield's internal appeal process, unless you are not required to


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exhaust Blue Cross and Blue Shield's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and

d. You have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Blue Cross and Blue Shield's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, your health care Provider has certified that one of the following situations is applicable:

a. Standard health care services or treatments have not been effective in improving your condition.

b. Standard health care services or treatments are not medically appropriate for you; or

c. There is no available standard health care services or treatment covered by Blue Cross and Blue Shield that is more beneficial than the recommended or requested service or treatment.

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.

3. **Notification.** Within one business day after completion of the preliminary review, Blue Cross and Blue Shield shall notify the IDOI, you and your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the IDOI, you and your authorized representative shall be notified by Blue Cross and Blue Shield in writing of what materials are required to make the request complete or the reason for its ineligibility. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the IDOI's decision shall be in accordance with the terms of your benefit program (unless such terms are inconsistent with applicable laws) and shall be subject to all applicable laws.

   a. **Assignment of IRO.** When the IDOI receives notice that your request is eligible for external review following the preliminary review, the IDOI will, within one business day after the receipt of the notice, a) assign an IRO on a random basis from those IROs approved by the IDOI; and (b) notify Blue Cross and Blue Shield, you and your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Within five business days after the date of receipt of the notice provided by the IDOI of assignment of an IRO, Blue Cross and Blue Shield 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 Blue Cross and Blue Shield or its designated utilization review organization does not provide the documents and information within five business days, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by Blue Cross and Blue Shield or designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the external review. Within one business day after making the decision to end the external review, the IRO shall notify Blue Cross and Blue Shield, you and, if applicable, your authorized representative, if applicable of its decision to reverse the determination.

If you or your authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to Blue Cross and Blue Shield within one business day of receipt from you or your authorized representative. Upon receipt of such information, Blue Cross and Blue Shield may reconsider the Adverse Determination or Final Adverse

Determination. Such reconsideration shall not delay the external review. Blue Cross and Blue Shield may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the external review, Blue Cross and Blue Shield shall notify the IDOI, IRO, you, and if applicable, your authorized representative of its decision to reverse the determination.

4. **IRO's Decision.** In addition, to the documents and information provided by Blue Cross and Blue Shield and you, or if applicable, your authorized representative, the IRO shall also consider the following information if available and appropriate:

   a. Your pertinent medical records.

   b. Your health care Provider's recommendation.

   c. Consulting reports from appropriate health care Providers and other documents submitted to Blue Cross and Blue Shield or its designee utilization review organization, you, your authorized representative, or your treating Provider.

   d. The terms of coverage under the benefit program.

   e. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations.

   f. Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield or its designated utilization review organization; and

   g. The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

Within one business day after the receipt of notice of assignment to conduct an external review with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the IRO will select one or more clinical reviewers, as it determines is appropriate, to conduct the external review, which clinical reviews must meet the minimum qualifications set forth in the Illinois Health Carrier External Review Act, and neither you, your authorized representative, if applicable, nor Blue Cross and Blue Shield will choose or control the choice of the Physicians or their 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 services or treatment should be covered.

The IRO will make a decision within 20 days after the date it receives the opinion of each clinical review, which will be determined by the recommendation for majority of the clinical reviewers.

Within five days after the date of receipt of the necessary information, but in no event more than 45 days after the date of receipt of request for an external review, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the IDOI, Blue Cross and Blue Shield, you and your authorized representative, if applicable of its decision.

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


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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 decisions; and

7. The rationale for its decision.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review.

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

| **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 |
| Blue Cross and Blue Shield shall complete a preliminary review of the request within: | 5 business days after receiving request |
| *Blue Cross and Blue Shield must notify you whether the request is complete and eligible for external review:* | |
| if the request is not complete Blue Cross and Blue Shield shall notify you and include what information or materials are required within: | 1 business day after the preliminary review |
| if the request is not eligible for external review Blue Cross and Blue Shield shall notify you and include the reasons for its ineligibility within: | 1 business day after the preliminary review |
| Blue Cross and Blue Shield shall notify the IDOI, you or your authorized representative that a request is eligible for external review within: | 1 business day after the preliminary review |
| The IDOI shall assign an independent review organization (IRO) within: | 1 business day after receipt of the notice. |
| Blue Cross and Blue Shield 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) |


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| 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 Blue Cross and Blue Shield fails to provide a decision on a request for an expedited internal appeal within: | 48 hours |
| *Blue Cross and Blue Shield 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 Blue Cross and Blue Shield's determination.* | |
| The IDOI shall assign an independent review organization (IRO): | Immediately |
| Blue Cross and Blue Shield shall provide all necessary documents and information to the IRO: | Immediately, but not more than 24 hours after assignment of an IRO |
| *If Blue Cross and Blue Shield 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 Blue Cross and Blue Shield, 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. |

| 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 |
| *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 Blue Cross and Blue Shield and the time frames otherwise applicable to Expedited External Review shall apply.* | |
| After the receipt for an external review, the IDOI shall send a copy of the request to Blue Cross and Blue Shield within: | 1 business day |
| Blue Cross and Blue Shield shall complete a preliminary review of the request within: | 5 business days |
| After completion of the preliminary review, Blue Cross and Blue Shield shall notify you or your authorized representative and the IDOI whether the request is complete and eligible for external review within: | 1 business day |
| *When the IDOI receives notice that the request is eligible for external review, the IDOI shall:* | |
| assign an IRO and notify Blue Cross and Blue Shield of the name of the IRO, within: | 1 business day |


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| | |
|---|---|
| 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: | 1 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: | 1 business day |
| Blue Cross and Blue Shield 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 Blue Cross and Blue Shield within: | 20 days |
| or, in the case of an expedited external review, within: | 48 hours after receipt of the opinion of each clinical reviewer |

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination; (b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received Emergency Services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of Final Adverse Determination or if Blue Cross and Blue Shield fails to provide a decision on 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 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 IDOI shall immediately send a copy of the request to Blue Cross and Blue Shield. Blue Cross and Blue Shield shall immediately notify the IDOI, you and your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, 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 Blue Cross and Blue Shield of the name of the IRO.

Upon receipt from the IDOI of the name of the IRO assigned to conduct the external review, Blue Cross and Blue Shield or its designated utilization review organization shall immediately (but in no case more than 24 hours after receiving such notice) provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may submit additional information in writing to the assigned IRO within 24 hours or additional information may accompany the request for an expedited independent external review. If Blue Cross and Blue Shield or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the external review, the IRO shall notify the IDOI, Blue Cross and Blue Shield, you and, if applicable, your authorized representative, of its decision to reverse the determination.

As expeditiously as your medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited external review) the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the IDOI, Blue Cross and Blue Shield, you and, if applicable, your authorized representative. If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the IDOI, Blue Cross and Blue Shield and, if applicable, your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of experimental or investigational treatments, each clinical review shall provide an opinion orally or in writing to the assigned IRO as expeditiously as your medical condition or circumstances requires, but in no event more than five calendar days after being selected. Within 48 hours after the date, it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing to the IDOI, the Claim Administrator, 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 Claim Administrator and, if applicable, your authorized representative.

The assigned IRO is not bound by any decisions or conclusions reached during Blue Cross and Blue Shield's utilization review process or Blue Cross and Blue Shield's internal grievance process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance's Office of Consumer Health Insurance.

An external review decision is binding on Blue Cross and Blue Shield. An external review decision is binding on you, except to the extent you have other remedies available under applicable federal or state law. You and your authorized representative may not file a subsequent request for external review involving the same Adverse Determination or Final Adverse Determination for which you have already received an external review decision.


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# GENERAL PROVISIONS

## BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers ("Plan Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under certain circumstances described in its contracts with Plan Providers, Blue Cross and Blue Shield may:

1. Receive substantial payments from Plan Providers with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Plan Provider.
2. Pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise; and
3. Receive from Plan Providers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Certificate and the calculation of all required Deductible and Coinsurance Amounts payable by you under this Certificate shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Group has been advised that Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Providers work, please consider the following example:

4. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?
5. You personally will have to pay the Deductible and Coinsurance Amounts set out in your Certificate.
6. However, for purposes of calculating your Deductible and Coinsurance Amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your Deductible and Coinsurance Amounts, and whether you have reached any out-of-pocket or benefit maximums.
7. Assuming you have already satisfied your Deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.
8. After taking into account the Deductible and Coinsurance Amounts, Blue Cross and Blue Shield will satisfy its portion of the Hospital bill. In most cases, Blue Cross and Blue Shield has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money Blue Cross and Blue Shield would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your Deductible has already been satisfied, and your Coinsurance is $140, then Blue Cross and Blue Shield has to satisfy the rest of the Hospital bill, or $860. Assuming Blue Cross and Blue Shield has a contract with the Hospital, Blue Cross and Blue Shield will usually be able to satisfy the $860 bill that remains after your Coinsurance and Deductible, by paying less than $860 to the Hospital, often substantially less than $860. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the $860 bill and whatever Blue Cross and Blue Shield ultimately pays under its contracts with Plan Providers, and neither you nor your Group are entitled to any part of these savings.

### Out-of-Area Services

### Overview


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Blue Cross and Blue Shield of Illinois ("BCBSIL"), a division of Health Care Service Corporation, has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." These Inter-Plan Programs operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BCBSIL serves, the claim for those services may be processed through one of these Inter-Plan Programs. The Inter-Plan Programs are described generally below.

When you receive care outside the geographic area BCBSIL serves, you generally obtain care from healthcare providers that have a contractual agreement ("participating providers") 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 healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BCBSIL explains how BCBSIL pays both kinds of providers below.

**Inter-Plan Programs Eligibility – Claim Types**

All claim types are eligible to be processed through Inter-Plan Programs, as described above, except for all dental care benefits, except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by BCBSIL to provide the specific service or services.

**1. BlueCard® Program**

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBSIL will remain responsible for doing what BCBSIL agreed to in the contract. However, the Host Blue is responsible for handling all interactions with its providers, including contracting with participating providers.

When you receive covered healthcare services outside BCBSIL's service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

a. The billed charges for your covered healthcare services; or

b. The negotiated price that the Host Blue makes available to BCBSIL.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your provider. Sometimes, it is an estimated price that considers 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 considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing also consider adjustments to correct for over or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSIL has used for your claim because they will not be applied after a claim has already been paid.

**2. Negotiated Arrangements**

With respect to one or more Host Blues, instead of using the BlueCard® Program, BCBSIL may process your claims for covered healthcare services through negotiated arrangements for national accounts.

The amount you pay for covered healthcare services will be calculated based on the lower of either billed charges for covered healthcare services or negotiated price (refer to the description of negotiated price under the BlueCard® Program section above) that the Host Blue makes available to BCBSIL.

Where the employer group agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, you will be responsible for the amount that the healthcare provider bills for a specified procedure above the reference benefit limit for that procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a provider's billed charge, you will incur no liability, other than any applicable patient cost sharing under this agreement.

**Special Cases: Value-Based Programs**

If you receive covered healthcare services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSIL through average pricing or fee schedule adjustments.

*Value-Based Programs: Negotiated Arrangements*

If BCBSIL has entered a negotiated arrangement with a Host Blue to provide value-based programs to your employer on your behalf, BCBSIL will follow the same procedures for value-based programs administration and care coordinator fees, as noted above, for the BlueCard® Program.

**Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to fully insured accounts. If applicable, BCBSIL will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

**3. Nonparticipating Providers Outside BCBSIL's Service Area**

**a. Member Liability Calculation**

When covered healthcare services are provided outside of BCBSIL's service area by nonparticipating providers, the amount(s) you pay for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCBSIL will make for the covered healthcare services as set forth in this paragraph. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services will be governed by applicable federal and state law.

In certain situations, BCBSIL may use other payment methods, such as billed charges for covered healthcare services, the payment BCBSIL would make if the healthcare services had been obtained within BCBSIL's service area, or a special negotiated payment to determine the amount BCBSIL will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment BCBSIL will make for the covered healthcare services as set forth in this paragraph.

**b. Blue Cross Blue Shield Global® Core (Blue Cross Blue Shield Global Solutions℠)**

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, (hereinafter: "BlueCard® service area"), you may be able to take advantage of Blue Cross Blue Shield Global® Core when accessing covered healthcare services. Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program available in the BlueCard® service area in certain ways. For instance, although Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard® service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard® service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

**i. Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services.

ii. **Outpatient Services**


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Physicians, urgent care centers and other outpatient providers located outside the BlueCard® service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

iii. **Submitting a Blue Cross Blue Shield Global® Core Claim**

When you pay for covered healthcare 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 claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSIL, 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.

4. **Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers**

Blue Cross and Blue Shield hereby informs you that it has arrangements 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 Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under its contracts with Participating Prescription Drug Providers, Blue Cross and Blue Shield may receive from these Providers discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of Prescription Drugs will vary. Some discounts are currently based on Average Wholesale Price ("AWP") which is determined by a third party and is subject to change.

You understand that Blue Cross and Blue Shield may receive such discounts. Neither the Group nor you are entitled to receive any portion of any discounts. The drug fees/discounts that Blue Cross and Blue Shield has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate your share of the cost of Prescription Drugs for both retail and home delivery/specialty drugs. Except for home delivery/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed through to the Plan (and ultimately to you as described above).

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 Blue Cross and Blue Shield for a prescription drug, whichever is lower.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

a. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is $100. How is the $100 bill 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 home delivery pharmacy and specialty pharmacy program partially owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the home delivery pharmacy and/or specialty pharmacy program. The 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 deliver processing.

"Weighted paid claim" refers to the methodology of counting claims for purposes of determining Blue Cross and Blue Shield's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy


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program) paid claim will be weighted according to the days' supply dispensed. A paid claim is weighted in 34-day supply increments so a 1 - 34 days' supply is considered 1 weighted claim, a 35 - 68 days' supply is considered 2 weighted claims and the pattern continues up to 6 weighted claims for 171 or more days' supply. Blue Cross and Blue Shield pays Prime a Program Management Fee ("PMF") on a per weighted claim days' supply.

The amounts received by Prime from the Plan, pharmacies, manufactures 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 manufactures. 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 manufacture for certain administrative fees will be 5.5% of the total sales for all rebatable products of such manufacture dispensed during any given calendar year to members of the Plan and other Blue Plan operating divisions.

5. **Blue Cross and Blue Shield's Separate Financial Arrangements with Pharmacy Benefit Managers**

Blue Cross and Blue Shield owns a significant portion of the equity of Prime Therapeutics LLC and informs you that Blue Cross and Blue Shield has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on Blue Cross and Blue Shield's behalf, Claim Payments, and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with Blue Cross and Blue Shield. 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.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Plan but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufactures to cover the administrative costs of processing late payments). The Plan may receive such rebates from Prime.

6. **PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS**

a. Under this Certificate, Blue Cross and Blue Shield has the right to make any benefit payment either directly to the Provider of the Covered Services or 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. For example, Blue Cross and Blue Shield may pay benefits to you if you receive Covered Services from a Non-Plan Provider. Blue Cross and Blue Shield is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request Blue Cross and Blue Shield not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, Blue Cross and Blue Shield will have no liability to you or any other person because of its rejection of such request.

c. Except for the Assignment of Benefit Payment described above, either this Certificate or a covered person's claim for benefits under this Certificate is expressly non-assignable and non-transferable to any person or entity, including any Provider, at any time before or after covered services are rendered to a covered person, 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. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

7. **YOUR PROVIDER RELATIONSHIPS**

a. The choice of a Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.


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b. Blue Cross and Blue Shield does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. Blue Cross and Blue Shield is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by Blue Cross and Blue Shield. Any contractual relationship between a Physician and a Plan Hospital or other Plan Provider shall not be construed to mean that Blue Cross and Blue Shield is providing professional service.

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

d. Each Provider provides covered services only to you and does not deal with or provide any services to your Group (other than as an individual covered person) or your Group's ERISA Health Benefit Program.

## 8. AGENCY RELATIONSHIPS

The Group is your agent under this Certificate. The Group is not the agent of Blue Cross and Blue Shield.

All information you and the Group provide to Blue Cross and Blue Shield will be relied upon as accurate and complete. The Group must promptly notify Blue Cross and Blue Shield of any changes to such information.

## 9. NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield under this Certificate must be in writing and sent to Blue Cross and Blue Shield at its offices at 300 East Randolph Street, Chicago, Illinois 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield's records or 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 Blue Cross and Blue Shield's records. Blue Cross and Blue Shield may also provide such notices electronically, to the extent permitted by applicable law.

## 10. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate, prior to the expiration of sixty (60) days after a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate.

## 11. INFORMATION AND RECORDS

You agree that it is your responsibility to ensure 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 indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield or its agent, and agree that any such Provider, person or other entity may furnish to Blue Cross and Blue Shield 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, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish Blue Cross and Blue Shield and/or your employer or Group Administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that Blue Cross and Blue Shield be able to make Claim Payments in accordance with MSP laws.

## 12. PHYSICAL EXAMINATION AND AUTOPSY


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Blue Cross and Blue Shield, at its own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

13. **WELLNESS PROGRAMS**

Blue Cross and Blue Shield and your employer have the right to offer medical management programs, quality improvement programs, and incentives for participation in any health behavior wellness, maintenance, or improvement programs that allows for a reward, a contribution, a differential in premiums or in medical, prescription drug or equipment Copayments, Coinsurance, Deductibles, or costs for participation in any such program offered or administered by Blue Cross and Blue Shield, or an entity chosen by Blue Cross and Blue Shield to administer such 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 with or without notice.

Individuals for whom it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable wellness program standard, or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable wellness program standard, shall be provided a reasonable alternative standard or waiver of the otherwise applicable standard, as required by applicable law. Blue Cross and Blue Shield may require verification, such as a statement from the individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable to satisfy or attempt to satisfy the wellness program standard, where permitted by law.

Participation in these programs is entirely voluntary. Participants shall have the opportunity to qualify for any available wellness program reward at least once each year. Wellness programs shall be reasonably designed to promote health or prevent disease, shall not be overly burdensome, shall not be a subterfuge for discriminating based on a health factor, and shall not be otherwise highly suspect in the method chosen to promote health or prevent disease. Wellness program rewards apply only to wellness coverage and do not apply to any other required or optional health care benefit. Rewards, in total, offered under a wellness program shall not exceed 30% of the cost of employee-only coverage under the plan. However, they may be increased to 50% of the cost of coverage if the additional percentage is in connection with a program designed to prevent or reduce tobacco use, as permitted by applicable law.

Contact Blue Cross and Blue Shield for additional information regarding any wellness program offered by Blue Cross and Blue Shield. Contact your employer for additional information regarding any wellness program offered by your employer.

Blue Cross and Blue Shield makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by Blue Cross and Blue Shields' 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 Blue Cross and Blue Shield does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this benefit program.

14. **CONFORMITY WITH STATE STATUTES**

This Certificate provides, at a minimum, coverage as required by Illinois law. Laws in some other states require that certain benefits or provisions be provided to you if you are a resident of their state when the policy that insures you is not issued in your state. In the event any provision of this Certificate, on its effective date, conflicts with the laws of the state in which you permanently reside, you will be provided the greater of the benefit under this Certificate or that required under the laws of the state in which you permanently reside.

15. **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 Services 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 from involuntary termination of your health coverage sponsored by the Group/Employer but solely as a result of a reduction in force, plant/office closing(s) or group health plan termination. 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 Certificate the Group/Employer 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.

16. **ENTIRE CONTRACT**

The entire contract consists of Group Policy, including the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, the Group's application and the Plan, as appropriate, along with any exhibits, appendices, addenda and/or other required information and the individual application(s) of the persons covered under the Certificate, benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Group Policy, to extend the time for payment of premiums, or to waive any of the rights or requirements of Blue Cross and Blue Shield. No modifications of the Group Policy will be valid unless evidenced by an endorsement or amendment of the Group Policy, signed by an executive officer of Blue Cross and Blue Shield and delivered to the Group.

17. **OVERPAYMENT**

If your Group's benefit plan or Blue Cross and Blue Shield pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or was made in error ("overpayment"), your Group's benefit plan and Blue Cross and Blue Shield has the right to obtain a refund of the overpayment from: (a) the person to, or for whom, such benefits were paid, or (b) any insurance company or plan, or

a. Any other persons, entities, or organizations, including, but not limited to, Participating Providers or Non-Participating Providers.

b. If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any overpayment due, up to an amount equal to the overpayment, from:

   i. Any future benefit payment owed to any person or entity under this Certificate, whether for the same or a different member; or,

   ii. Any future benefit payment owed to any person or entity under another Blue Cross and Blue Shield administered Administrative Service Only (ASO) benefit program; or,

   iii. Any future benefit payment owed to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or,

   iv. Any future benefit payment, or other payment, owed to any person or entity; or,

   v. Any future payment owed to one or more Participating Providers or Non-Participating Providers.

Further, Blue Cross and Blue Shield has the right to reduce your Group's benefit plan or policy's payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield plans or policy's overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield's plan or policy.

**18. FEDERAL BALANCE BILLING AND OTHER PROTECTIONS**

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Illinois law, if there is a conflict between the terms of this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section and the terms in the rest of this Certificate, the terms of this section will apply. However, definitions set forth in the **FEDERAL NO SURPRISES ACT DEFINITIONS** provision of this section are for purposes of this section only.

**Continuity of Care**

If you are under the care of a Participating Provider as defined in this Certificate who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

a. You are undergoing a course of treatment for a serious and complex condition,
b. You are undergoing institutional or Inpatient care,
c. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
d. You are pregnant or undergoing a course of treatment for your pregnancy, or
e. You are determined to be terminally ill.

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

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

**Federal No Surprises Act Definitions**

The definitions below apply only to this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section. To the extent the same terms are also defined in the **DEFINITIONS SECTION** of this Certificate, those terms will apply only to their use in the Certificate or this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section, respectively.

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

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

"**Emergency Services**" means, for purposes of this section only.

1. A medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;

2. 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

3. Covered Services you receive from a Non-Participating Provider during the same visit after your Emergency Medical Condition has stabilized unless:
   a. Your Non-Participating Provider determines you can travel by non-medical or Non-Emergency transport;


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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 section only, with respect to a covered item or service, a Physician or other health care provider who does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan.

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

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

"**Participating Facility**" means, for purposes of this section only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSIL setting a rate (above which the Provider cannot bill the member) for furnishing such item or service under the Plan, regardless of whether the Provider is considered a preferred or in-network Provider for purposes of in-network or out-of-network benefits under the Plan.
"**Qualifying Payment Amount**" means, for purposes of this section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"**Recognized Amount**" means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or Billed Charges.

**Federal No Surprises Act Surprise Billing Protections**

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

a. Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.

b. Covered Non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections).

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

**Claim Payments**

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider. Additionally, under Illinois law, in the event there is a payment dispute between the Non-Participating Provider and BCBSIL, and attempts to negotiate a payment resolution are unsuccessful, the Non-Participating Provider or BCBSIL may initiate binding arbitration by filing a request with the Department of Insurance. The requesting party shall notify the non-requesting party that arbitration has been initiated, along with its final offer for settlement. The non-requesting party must also share its final offer with the requesting party before arbitration occurs. In the event there is still no resolution regarding the payment of services, the parties may move forward in the arbitration process with an impartial third-party arbiter pursuant to the provisions in 215 ILCS 5/356z.3a.

**Cost-Sharing**

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

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

For Included Services, these cost-share requirements will be counted toward your Participating Provider Deductible and/or Out-of-Pocket Limit, if any.

**Federal No Surprises Act Prohibition of Balance Billing**

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

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

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

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


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## 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 are provided for Covered Services described in this Certificate, you agree:

1. Blue Cross and Blue Shield has the right to reimbursement for all benefits Blue Cross and Blue Shield provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which Blue Cross and Blue Shield has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

2. Blue Cross and Blue Shield is assigned the right to recover from the third party, or their insurer, to the extent of the benefits Blue Cross and Blue Shield provided for that sickness or injury.

Blue Cross and Blue Shield shall have the right to first reimbursement out of all funds you, your covered dependents, or your legal representative, are or were able to obtain for the same expenses for which Blue Cross and Blue Shield has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that Blue Cross and Blue Shield may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.


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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 thestate 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 benefitplan 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 notguarantee, 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 orretirement 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 Insurance4th Floor
320 West Washington StreetSpringfield, 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 anyinconsistency 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)


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BlueCross BlueShield of Illinois

A Division of Health Care Service 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:

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| Office of Civil Rights Coordinator | Phone: | 855-664-7270 (voicemail) |
| Attn: Office of Civil Rights Coordinator | TTY/TDD: | 855-661-6965 |
| 300 E. Randolph St., 35th Floor | Fax: | 855-661-6960 |
| Chicago, IL 60601 | Email: | civilrightscoordinator@bcbsil.com |

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

| | | |
|---|---|---|
| US Dept of Health & Human Services | Phone: | 800-368-1019 |
| 200 Independence Avenue SW<br>Room 509F, HHH Building<br>Washington, DC 20201 | TTY/TDD:<br>Complaint Portal:<br>ocrportal.hhs.gov/ocr/smartscreen/main.jsf<br>Complaint Forms:<br>hhs.gov/civil-rights/filing-a-complaint/index.html | 800-537-7697 |

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.

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| Español<br>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<br>Arabic | تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة. |

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| 中文<br>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<br>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<br>German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider. |
| ગુજરાતી<br>Gujarati | ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. |
| हिंदी<br>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<br>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<br>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<br>Navajo | SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih. |
| فارسي<br>Farsi | توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید. |
| Polski<br>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<br>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<br>Tagalog | PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider. |
| اردو<br>Urdu | توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ |
| Việt<br>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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# Extraterritorial Rider Supplement for Your Benefit Booklet

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# Extraterritorial Rider
# Supplement to Your Benefit Booklet

## Introduction

This is a Supplement to your Benefit Booklet. If you permanently reside in one of the states specified in the Table of Contents, please read this carefully.

While this contract is issued in Illinois, the laws in some states require BCBSIL to provide certain specified benefits or apply differential handling for claims to permanent residents of that state who are members on this contract. This supplement includes Riders that describe how the coverage for permanent residents in these states differ from those residing in Illinois. If you are a permanent resident of one of the states in the Table of Contents, the benefits described in the Rider for that state apply to you.

In the event of a conflict between the Benefit Booklet and the Rider for the state in which you permanently reside, the provisions resulting in greater benefits will be in effect. Except as amended by the Rider, all terms, conditions, limitations, and exclusions of the Benefit Booklet to which the Rider apply and is hereby attached will remain in full force and effect.

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300 East Randolph
Chicago, IL 60601

## RIDER FOR RESIDENTS OF THE STATE OF CALIFORNIA

If you are a resident of the state of California, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of California. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

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

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

1. The ***ELIGIBILITY*** section, ***ELIGIBILITY, ENROLLMENT AND TERMINATION INFORMATION*** section, ***WHO GETS BENEFITS*** section, or similar section in your Benefit Booklet describing who is eligible to receive **benefits**, is amended to include the following:

   **a. Domestic Partner Coverage**
   Coverage for a registered domestic partner of a **participant** will be provided on the same basis as coverage for a spouse of a **participant**. We cannot discriminate in coverage between spouses or domestic partners of a different sex or of the same sex.

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

**Effective Date of Rider: January 1, 2026, or the date on which your coverage begins under the group contract, whichever is later.**

**Blue Cross and Blue Shield of Illinois,**
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**a Mutual Legal Reserve Company**

**Brian Snell**
**President**
**Blue Cross and Blue Shield of Illinois**

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of Illinois

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The benefits of the group contract providing your coverage are governed primarily by the law of a state other than Florida.

## RIDER FOR RESIDENTS OF THE STATE OF FLORIDA

If you are a resident of the state of Florida, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Florida. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater benefits will be in effect.

The following terms are used in this Rider:

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the **group contract**.

"**Group contract**" means "Group Policy, "Group Contract", or "Contract", as defined in your Benefit Booklet.

"**Group contractholder**" means "Group Policyholder" or "Group Contractholder", as defined in your Benefit Booklet.

"**Participant**" means "participant", "covered person", "insured person", "insured member", "subscriber", "beneficiary member", "Member", or your "dependent", as may be defined in your Benefit Booklet.

"You" or "Your" used in this Rider means the insured employee or insured member who is covered under the **group contract**.

Some terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

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*Rider Section Titles*

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

1. The following notice is added to the cover page of your Benefit Booklet:
   **The benefits of the group contract providing your coverage are governed primarily by the law of a state other than Florida.**

2. The ***WHO GETS BENEFITS*** section, ***ELIGIBILITY, ENROLLMENT AND TERMINATION INFORMATION*** section, or ***ELIGIBILITY AND ENROLLMENT*** section, whichever is applicable, in your Benefit Booklet is hereby amended to include the following provisions:

   **a. Coverage for Newborn Children**
   Your newborn **child** will be covered under the **group contract** from the moment of birth. A newborn **child** of your d**ependent child** will be covered under the **group contract** from the moment of birth. However, coverage for such newborn **child** will terminate eighteen (18) months after his or her birth, unless your coverage terminates under the **group contract** prior to the end of the eighteen (18) months.

   To update your membership records, please provide written notification to your employer, the **group contractholder**, or the Group Plan Administrator, as applicable, within thirty-one (31) days of the date of birth of:
   - Your newborn **child**, or
   - The newborn **child** of your **dependent child**

   If you give written notice of the birth of your newborn **child** within the thirty-one (31) day period, any additional premium required for the coverage of your newborn **child** will not be charged for the duration of the thirty-one (31) day-notice period. If you fail to provide written notification of the birth of your newborn **child** within the thirty-one (31) day period, but you do so within sixty (60) days of the date of birth of your newborn child:

   - You must pay any premium required for the coverage of your newborn **child** from the date of birth, and
   - Coverage for your newborn **child** will not be denied during the 60-day period

b. The ***COVERED SERVICES*** section of the Benefit Booklet, or other sections of the Benefit Booklet specifying covered medical services in the Benefit Booklet, is hereby amended to include the following:

a. **Child Health Supervision Services**
**Covered services** include **child health supervision services** for a **dependent child** from the moment of birth to age sixteen (16). Coverage includes:

1. A collection and assessment of medical history
2. A periodic physical examination, as may be appropriate
3. A developmental assessment and anticipatory guidance
4. Appropriate immunizations
5. Appropriate laboratory tests

Such services and periodic visits will be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

**Child health supervision services** are not subject to any **deductibles.**

**Child health supervision services** means **physician**-delivered or **physician**-supervised services that include, at a minimum, benefit coverage for services delivered at the intervals and scope stated above in this provision.

b. **Cleft Lip and Cleft Palate**
**Covered services** include the treatment of cleft lip and cleft palate for a **dependent child**. Coverage will include the following services when prescribed by the treating **physician** or surgeon:

6. Medical services
7. Dental services
8. Speech therapy services
9. Audiology services
10. Nutrition services

The **physician** or surgeon must certify that such services are:

11. **Medically necessary**, and
12. Consequent to treatment of the cleft lip or cleft palate

c. **Dental Services and Anesthesia in a Hospital or Ambulatory Surgery Center**

**Covered services** include general anesthesia and hospitalization services when a dental treatment or surgery is necessary for a dental condition that has a prognosis of resulting in a medical condition if left untreated if the **participant:**

- Is under eight (8) years of age and is determined by a dentist and the **participant's physician** to require necessary dental treatment in a **hospital** or ambulatory surgical center due to:
  - A significantly complex dental condition, or
  - A developmental disability, and

  in which patient management in the dental office has proved to be ineffective, or
- Has one more medical conditions that would create significant or undue medical risk for the **participant** in the course of delivery of any necessary dental treatment or surgery if not rendered in a **hospital** or ambulatory surgical center

No coverage will be provided under this benefit for the diagnosis or treatment of dental disease.

d. **Follow-Up Care for Breast Cancer**

**Covered services** include follow-up care for breast cancer to determine whether a breast cancer has recurred in a **participant** who has been previously determined to be free of breast cancer.

e. **Mammogram Benefit – Routine Mammograms**

**Covered services** include low-dose mammography screening for all female **participants as follows:**

- A baseline mammogram for any female **participant** who is 35 years of age or older, but younger than 40 years of age
- A mammogram every two (2) years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the recommendation by the female **participant's physician**
- A mammogram every year for any woman who is 50 years of age or older. The mammography screening includes:
  - X-ray examination
  - Digital mammography, and
  - Breast tomosynthesis for the presence of breast cancer, even if no symptoms are present

If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening and magnetic resonance imaging (MRI) screening of an entire breast or breasts, when determined to be **medically necessary** by the female **participant's physician**.

f. **Mammography Benefit for Women at Risk for Breast Cancer**

**Covered services** include one or more mammograms based on a **physician's** recommendation for any female **participant** who is at risk for breast cancer due to:

- A family history of breast cancer
- Prior personal history of breast cancer
- Positive genetic testing
- Not given birth before age thirty (30)
- A history of biopsy-proven benign breast disease, or
- Other risk factors

g. **Maternity Care Services**

**Covered services** include **maternity care services** provided on the same basis as any other sickness covered under the **group contract**. **Maternity care services** include services provided by:

- A licensed Certified Nurse-Midwife
- A licensed Midwife
- A licensed Birth Center

***Hospital Length of Stay and Follow-Up Care***

The time period for the length:

- Of a maternity and newborn stay in a **hospital**, or
- For follow-up care outside of a **hospital**

will not be less than the time period determined to be **medically necessary:**

- In accordance with prevailing medical standards, and
- Consistent with guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists

by the treating obstetrical care **provider**, or the pediatric care **provider.**

***Postdelivery Care***

**Covered services** include the following services for postdelivery care of a mother and her newborn infant:

- A postpartum assessment and newborn assessment provided at:
  - The **hospital**
  - The attending **physician's** office
  - An outpatient maternity center, or

- The home of the mother by a qualified licensed health care professional trained in mother and baby care
- The postpartum assessment services must include:
  - Physical assessment of the newborn and mother
  - The performance of any **medically necessary** clinical tests and immunizations in keeping with prevailing medical standards

h. **Mastectomy-Related Services**

**Covered services** include the following services related to **mastectomies** on the same basis as other conditions covered under the **group contract**:

- Prosthetic devices, and
- Breast reconstructive surgery incident to the **mastectomy**

**Mastectomy** means the removal of all or part of the breast for **medically necessary** reasons as determined by a **physician**.

**Breast reconstructive surgery** means surgery to reestablish symmetry between the two breasts.

i. **Newborn Child Coverage**

**Covered services** for your newborn **child** or the newborn **child** of your **dependent** child include:

- Coverage for injury or sickness, including the necessary care or treatment of medically diagnosed:
  - Congenital defects
  - Birth abnormalities, or
  - Prematurity
- Coverage for ambulance transportation costs for the newborn **child** to and from the nearest available facility appropriately staffed and equipped to treat the newborn **child's** condition if the transportation is certified by the attending **physician** as **medically necessary** to protect and safety of the newborn **child**

j. **Osteoporosis Benefit**

**Covered services** include the **medically necessary** diagnosis and treatment of osteoporosis for high-risk **participants**, including, but not limited to:

- Estrogen-deficient **participants** who are at clinical risk for osteoporosis
- **Participants** who have vertebral abnormalities
- **Participants** who are receiving long-term glucocorticoid (steroid) therapy
- **Participants** who have primary hyperparathyroidism
- **Participants** who have a family history of osteoporosis

k. **Post-Surgical Mastectomy Care Covered services** include:

- Inpatient **hospital** coverage for mastectomies will be provided for the period determined by the treating **physician** to be **medically necessary:**
  - In accordance with prevailing medical standards, and
  - After consultation with the **participant**
- Coverage for outpatient postsurgical follow up care in keeping with prevailing medical standards by a licensed health care professional qualified to provide postsurgical mastectomy care. The treating **physician**, after consultation with the **participant**, may choose that the outpatient care be provided at the most medically appropriate setting, which may include:
  - The **hospital**
  - The treating **physician's** office
  - The Outpatient center, or
  - The home of the **participant**

l. **Treatment for Jaw and Facial Bones and Joint Disorders**

**Covered services** include any diagnostic or surgical procedure involving bones or joints of the jaw and facial region, if, under accepted medical standards, such procedure or surgery is **medically necessary** to treat conditions caused by:

- Congenital or developmental deformity
- Disease, or
- Injury

This benefit does not cover:

- Care or treatment of teeth or gums
- Intraoral prosthetic devices, or
- Surgical procedures for cosmetic purposes

c. The ***GENERAL PROVISIONS*** section, ***ELIGIBILITY, ENROLLMENT AND TERMINATION INFORMATION*** section, or ***TERMINATION OF COVERAGE*** section of the Benefit Booklet is amended to include the following provisions:

a. **Conversion Privilege**

If you are covered under the **group contract**, whichever is applicable, as an insured employee or insured member of:

1. The **group contractholder**, or
2. An Employer Member

and your coverage terminates under the **group contract** for any reason, except as specified below, you may convert your coverage to conversion coverage, without evidence of insurability, provided:

3. You have been covered under the **group contract** for at least three (3) consecutive months prior to termination, and
4. You elect conversion coverage and pay the required premium within the period required as indicated in this provision

You may also convert your group coverage, if your coverage terminates under the **group contract** due to retirement, and you:

5. Have been covered under the **group contract** for at least three (3) consecutive months prior to retirement, and
6. Are not eligible for Medicare

You will not be eligible for conversion coverage if:

7. Your coverage under the **group contract** terminated because you failed to pay any required premium contribution, unless such nonpayment of premium was due to acts of the **group contractholder**, or Employer Member, or a person other than you
8. Your Employer Member's participation under the **group contract** terminates, and the Employer Member replaces the **group contract** coverage with similar group coverage within thirty-one (31) days after termination
9. The **group contractholder** terminates the **group contract** and replaces the **group contract** coverage with similar group coverage within thirty-one (31) days after termination; this also applies if your Employer Member is a participating employer under the replaced **group contract**
10. You are eligible for coverage under Medicare
11. You are covered for similar benefits by another:

a. hospital, surgical, medical or major medical expense insurance policy, or
b. hospital or medical service subscriber policy, or
c. medical practice or other prepayment plan, or
d. any other plan

12. You are eligible for similar benefits, whether or not covered thereby, under any arrangement of coverage for individuals in a group, whether on an insured basis or uninsured, or
13. You are entitled to receive similar benefits pursuant to or in accordance with the requirements of any state or federal law

*Conversion Coverage Under the **Group Contract***
The conversion coverage offered by Blue Cross and Blue Shield will be coverage provided under the **group contract**. If you elect conversion coverage under the **group contract**, you will be:

14. Enrolled as a conversion enrollee under the **group contract**
15. Provided a group certificate for the conversion coverage, and
16. Responsible for the premium payments

The conversion coverage will be the same benefits as provided under the **group contract**, and such benefits will be changed if the **group contract** benefits change.

Under the conversion coverage, you may include coverage for your **dependents** who were insured under the **group contract** on the date your coverage terminated under the **group contract**. Also, any such **dependents** may be covered under a separate conversion coverage enrollment under the **group contract**. Conversion coverage will be provided for your newly eligible **dependents** who are acquired after the effective date of your conversion coverage subject to any notification and premium requirements.

The effective date of the conversion coverage under the **group contract** will be the day following the termination date of your insurance under the **group contract** as an insured employee or member.

*Notification and Election*
You must notify Blue Cross and Blue Shield, the **group contractholder**, the Employer Member, and/or the Group Plan Administrator, as applicable, that you are considering applying for conversion coverage and want conversion information. Within fourteen (14) days after your request is received for conversion information, the following items will be provided to you:

17. a conversion election form or a conversion application form
18. premium rate information for the conversion coverage, and
19. a summary of the conversion coverage available to you

Your completed and signed conversion election form or conversion application form and the first premium for the conversion coverage must be submitted to the address shown in the conversion election form or conversion application form no later than sixty-three (63) days after the date the above information was provided to you.

*Conversion Coverage After Continuation Coverage*
If you qualify for COBRA continuation coverage or any other continuation coverage provided under the **group contract**, conversion coverage will take place at the end of such continuation period, if:

20. the completed conversion election form or conversion application form, and
21. the applicable premium payment

are submitted to the address indicated in the conversion election form or conversion application form within thirty (30) days of the date coverage ended under the continuation coverage. If you elect this Conversion Privilege prior to your enrollment in any continuation coverage for which you may qualify under the **group contract**, the continuation coverage will no longer be available to you.

*Conversion for Dependents Who No Longer Qualify as Dependents*
Subject to the above requirements of this Conversion Privilege provision, this Conversion Privilege will also be available to your insured **dependents** whose coverage terminate under the **group contract** for any of the following reasons:

22. Your surviving **dependent** spouse and surviving **dependent children**, if any, whose coverage under the **group contract** terminate upon your death
23. Your former **dependent** spouse whose coverage terminates under the **group contract** because of annulment or dissolution of marriage, if the former **dependent** spouse is dependent on you for financial support
24. Your **dependent** spouse and **dependent children** whose coverage under the **group contract** terminate at the same time because they cease to be qualified family members, while you remain insured under the **group contract**, or
25. Your **dependent child** whose coverage terminates under the **group contract**

because he or she no longer qualifies as a family member
If any of the above **dependents** qualify for COBRA continuation coverage or any other continuation coverage provided under the **group contract**, conversion coverage will take place at the end of such continuation period, if:

26. the completed conversion election form or conversion application form, and
27. the applicable premium payment

are submitted to the address indicated in the conversion election form or conversion application form within thirty (30) days of the date coverage ended under the continuation coverage. If this Conversion Privilege is elected prior to the **dependents'** enrollment in any continuation coverage for which the **dependents** may qualify under the **group contract**, the continuation coverage will no longer be available to such **dependents**.

b. **Extension of Benefits for Covered Disability**
If you are totally disabled on the date of termination of:
1. The **group contract**, or
2. Your Employer Member's participation under the **group contract**

coverage under the **group contract** will be continued for **covered services** in connection with the treatment of a specific accident or illness incurred while the **group contract** was in effect. This extension of benefits will be provided for the total disability regardless of whether the **group contractholder**, or Employer Member, obtains replacement coverage from a new insurer or foregoes the provision of coverage.

The extension of benefits will be provided for twelve (12) months.

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

**Effective Date of Rider: August 1, 2026, or the date on which your coverage begins under the group contract, whichever is later.**

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

**Brian Snell President**

BlueCross BlueShield
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300 East Randolph
Chicago, IL 60601

## RIDER FOR RESIDENTS OF THE STATE OF INDIANA

If you are a resident of the state of Indiana, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Indiana. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

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

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

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1. The ***COVERED SERVICES*** section, or similar section in your Benefit Booklet describing your covered **benefits**, is amended to include the following **benefits**:

   **a. Minimum Maternity Benefits – At-home Postdelivery Care**
   **Covered services for at-home postdelivery care include:**
   - Assistance and training in breast or bottle feeding
   - Parent education
   - Performance of any maternal and neonatal tests routinely performed during the course of inpatient care for the woman or her newborn **child**, including the collection of an adequate sample for the hereditary and metabolic newborn screening

   **At-home postdelivery** care refers to health care provided to a woman at her residence by a licensed **physician**, registered nurse or an advance practice registered nurse whose scope of practice includes providing postpartum care in the area of maternal and child health care.

   **d. Minimum Maternity Benefits – Minimum Postpartum Stay; Newborn Examinations**
   **Covered services** provide the following minimum maternity **benefits** to a mother and her newborn child that cover:
   - A minimum length of postpartum stay at a licensed **hospital** that is consistent with the minimum postpartum **hospital** stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care
   - The examinations of the newborn **child** required under Indiana law
   - The testing of the newborn **child** required under Indiana law

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

**Effective Date of Rider: January 1, 2026, or the date on which your coverage begins under the group contract, whichever is later.**

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**a Mutual Legal Reserve Company**

**Brian Snell**
**President**
**Blue Cross and Blue Shield of Illinois**

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## RIDER FOR RESIDENTS OF THE STATE OF KANSAS

If you are a resident of the state of Kansas, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Kansas. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

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

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

1. The ***ELIGIBILITY*** section, ***ELIGIBILITY, ENROLLMENT AND TERMINATION INFORMATION*** section, ***WHO GETS BENEFITS*** section, or similar section in your Benefit Booklet describing who is eligible to receive **benefits**, is amended to include the following:

   **a. Open Enrollment**
   No **participant** will be excluded from eligibility or coverage under the group contract, except when either:
   - You choose to not be covered by the group contract
   - You or a **dependent** enroll after the open enrollment opportunity has closed

   An open enrollment opportunity is the period beginning on the date of your initial eligibility and ends thirty-one (31) days after the initial eligibility date.

   **b. Newborn Infant and Adopted Child**
   Coverage for your newly born **child** will become effective upon the moment of birth**.**

   Coverage for your adopted **child** will become effective upon one (1) of the following**:**
   - The moment of birth, if a petition for adoption was filed within thirty-one (31) days after the birth of the **child**
   - The date the petition for adoption was filed
   - The certified date of placement if the **child** is placed in your home by a child placement agency for the purpose of adoption

   It is required that in no case will the time from the date of placement to the date the petition for adoption is filed, exceed 280 days.

   Coverage will continue beyond the initial thirty-one (31) day period if you take the following actions within the initial thirty-one (31) day period:
   - Notify us about one (1) of the following:
     - The birth of your **child**
     - The filing of the petition for adoption
     - The certification that a **child** has been placed in your home for adoption
   - Pay any required premiums for the **child**

2. The ***COVERED SERVICES*** section, or similar section in your Benefit Booklet describing your covered **benefits**, is amended to include the following **benefits**:

   **a. Breast Reconstruction**
   **Covered services** include **medically necessary** reconstructive surgery following a mastectomy in the manner determined by the attending physician and the patient to be appropriate. These services include:
   - Reconstruction of the breast on which the mastectomy has been performed
   - Surgery on the other breast to make it symmetrical with the reconstructed breast.

- Prostheses
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas

**b. Dental Care – General Anesthesia and Medical Care Facility**

**Covered services** will include the administration of **medically necessary** general anesthesia and **medical care facility** costs for dental care provided to any of the following:

- A **child** five (5) years old or younger
- A **participant** who is severely disabled
- A **participant** who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided

**Covered services** do not include any dental procedures.

**Medical care facility** means a **hospital**, ambulatory surgical center, or recuperation center.

**c. Inpatient Stay for Post-Maternity Care**

**Covered services** include inpatient care for a mother and her newborn **child** in a medical care facility as follows:

- A minimum of forty-eight (48) hours of inpatient care following a vaginal delivery
- A minimum of ninety-six (96) hours of inpatient care following a cesarean delivery

Any decision to shorten the length of inpatient stay to less than that provided will be made by the **attending physician**.

If the newly born **child** is delivered in the home, coverage of inpatient care is not required unless determined to be **medically necessary** by the **attending physician.**

**Attending physician** means the person licensed to practice medicine and surgery who is responsible for the care provided to the mother or newborn.

**d. Newborn Infant**

**Covered services include:**

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities
- Routine and necessary immunizations for all newly born **children** from birth to six (6) years of age which will include:
    - Five (5) doses of vaccine against diphtheria, pertussis, tetanus
    - Four (4) doses of vaccine against polio and Haemophilus B (Hib)
    - Three (3) doses of vaccine against Hepatitis B
    - Two (2) doses of vaccine against measles, mumps, and rubella

- One (1) dose of vaccine against varicella
- Other vaccines and dosages as may be prescribed by the Secretary of Health and Environment

These immunizations will not be subject to any **deductibles, copayments**, or **coinsurance**.

**e. Osteoporosis**

**Covered services** include the diagnosis, treatment, and management of osteoporosis provided by a person licensed to practice medicine and surgery in Kansas, for participants with a condition or medical history for which bone mass measurement is **medically necessary**.

**f. Services Provided by a Psychologist**

Services within the scope of a licensed psychologist will be covered when performed by either a licensed psychologist or **physician**.

**g. Services Provided by a Specialist Social Worker**

Services within the scope of a licensed specialist social worker authorized to engage in private, independent practice will be covered when performed by either a licensed specialist social worker or **physician**.

**h. Treatment of Mental Conditions and Substance Abuse**

**Covered services** include treatment for the following:

- Mental illness in a licensed medical care facility
- Alcoholism, drug abuse, or substance use disorders in any of the following licensed facilities:
  - A treatment facility for alcoholics
  - A treatment facility for drug abusers
  - A community mental health center or clinic
  - A psychiatric **hospital**

Coverage does not include:

- Any assessment required by a diversion agreement or by order of a court to attend a certified alcohol and drug safety action program
- Evaluations and diagnostic tests ordered or requested in connection with
  - Criminal actions
  - Divorce
  - **Child** custody or **child** visitation proceedings

3. The ***OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS*** section, ***OUTPATIENT DRUGS AND MEDICINES PROGRAM*** section, ***PHARMACY BENEFITS*** section, or similar section in your Benefit Booklet describing your prescription drug benefits, is amended to include the following **benefits**:

**a. Mental Illness Prescription Drugs**
**Covered drugs** include psycho-therapeutic drugs prescribed for the treatment of mental illness. Coverage will be no less favorable than the coverage for other prescription drugs.

**b. Off-Label Cancer Prescription Drugs**
**Covered drugs** include Food and Drug Administration (FDA) approved drugs to be used in cancer treatment, even if the drug has not been approved by the FDA for that particular treatment. The drugs must be recognized for cancer treatment in either of the following:

- A substantially accepted peer-reviewed medical literature
- A nationally recognized compendium

The prescribing **physician** shall submit to us documentation supporting the proposed off-label use or uses if requested.

The following are not covered services:

- Any drug when the FDA has determined the drug's use to be contraindicated
- An experimental drug not approved for any indication by the FDA

**Peer-reviewed medical literature** means a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals. **Peer-reviewed medical literature** does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

**c. Orally Administered Anticancer Medications**
**Covered drugs** include prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. These drugs will be provided on a basis no less favorable than injected or intravenously administered cancer medications.

4. The ***GENERAL PROVISIONS*** section, or similarly named section in your Benefit Booklet, is amended to include the following:

**a. Subrogation Prohibition**
If your Benefit Booklet includes a provision about subrogation, it is no longer applicable to your group contract.

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

**Effective Date of Rider: January 1, 2026, or the date on which your coverage begins under the group contract, whichever is later.**

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## RIDER FOR RESIDENTS OF THE STATE OF MARYLAND

If you are a resident of the state of Marylabf, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Maryland. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

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

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

1. The ***COVERED SERVICES*** section, or similar section in your Benefit Booklet describing your covered benefits, is amended to include the following benefits:

   **a. Licensed Professional Counselor Services**
   **Covered services** will include medically necessary services performed in an appropriate setting and manner that fall within the lawful scope of practice of any of the following licensed providers:
   - A clinical professional counselor
   - A clinical marriage and family therapist
   - A clinical alcohol and drug counselor
   - A clinical professional art therapist

   **b. Nurse Anesthetist Services**
   **Covered services** for a **nurse anesthetist** will be provided regardless of whether the services are performed by a **physician** or a **nurse anesthetist**. Coverage will not be subject to the **nurse anesthetist** being employed by a **physician**.

   A **nurse anesthetist** means a registered nurse who is certified as a **nurse anesthetist** by either:
   - The Council on Certification of Nurse Anesthetists
   - The Council on Recertification of Nurse Anesthetists

   **c. Nurse Midwife Services**
   **Medically necessary** services performed in an appropriate setting and manner and provided within the legal scope of practice of a **nurse midwife** will be covered regardless of whether the service is provided by a **physician** or a **nurse midwife**.

   Coverage will not be subject to the **nurse midwife** being employed by a **physician** or acting under a **physician's** orders.

   A **nurse midwife** means a licensed registered nurse who is certified as a **nurse midwife** by the American College of Nurse-Midwives.

   **d. Optometrist Services**
   **Medically necessary** services performed in an appropriate setting and manner and provided within the legal scope of practice of an optometrist will be covered if the optometrist is licensed under the Health Occupations Article.

   **e. Health Care Provider**
   **Medically necessary** services performed in an appropriate setting and manner and provided within the legal scope of practice of a health care **provider** licensed under the Health Occupations Article will be covered. These providers include:
   - A clinical alcohol and drug counselor
   - A clinical marriage and family therapist

- A clinical professional art therapist
- A clinical professional counselor
- A graduate alcohol and drug counselor
- A graduate marriage and family therapist
- A graduate professional art therapist
- A graduate professional counselor

**f. Psychologist Services**

**Medically necessary** services performed in an appropriate setting and manner and provided within the legal scope of practice of a licensed psychologist will be covered regardless of whether the service is provided by a physician or licensed psychologist.

**g. Home Medical Equipment Coverage**

**Covered services** include **medically necessary** home medical equipment. We will pay the **provider** directly for home medical equipment if the **participant** has an executed assignment of **benefits** with a **provider**. The **provider** will not receive a lower payment than the amount agreed upon, subject to the **copayment** and **deductible** amounts.

We are required to notify both the **provider** and **participant** before authorization is terminated.

Home medical equipment and services may be purchased with our and the **provider's** consent if both:

- The purchase or rental prices of the equipment are disclosed to us before the initial election to rent the equipment or on our receipt of the initial claim from the **provider**
- The attending **physician** certifies there is no change in the medical condition of the **participant**

**h. House Confinement: Treatment Elsewhere**

**Covered services** for a **participant** confined to home due to disability or sickness will be extended if the individual leaves home for medical treatment. The services will be covered regardless of the place of medical treatment.

**i. Treatment in Public Hospitals or Institutions**

**Covered services** for the treatment of tuberculosis, mental illness, or another illness received in a **hospital** or other institution of the state or of a county or municipal corporation of the state, will be covered whether or not the **hospital** or other institution is deemed charitable.

2. The ***GENERAL PROVISIONS*** section, or similarly named section in your Benefit Booklet, is amended to include the following provisions:

   **a. Conversion of Group Health Insurance Policy**
   If you are covered under a group contract that includes disability benefits and your membership terminates for any reason other than failure to pay a required premium or contribution, you are entitled, without evidence of insurability, to an individual disability income insurance policy issued by a Maryland licensed issuer which offers such coverage. Where we do not offer such coverage in Maryland, information on how to access such coverage from an alternative issuer will be provided to you.

   A policy issued under this section will be eligible to take effect immediately after the termination of coverage under the group contract if the **participant** does both of the following:
   - Makes a timely written request for an individual policy
   - Pays the first premium for the individual policy

   This policy will be guaranteed renewable for the term or to the limiting age for which **benefits** would have been provided.

   You will be provided the option to enroll in coverage where the level of benefits under an individual policy issued under this section will equal approximately the disability benefits that would have been provided if coverage under the group contract had not terminated.

   We may limit the right of conversion to participants who were previously covered under the group contract for at least one (1) year.

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

**Effective Date of Rider: January 1, 2026, or the date on which your coverage begins under the Group Policy or Group Contract, whichever is later.**

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**Brian Snell**
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## RIDER FOR RESIDENTS OF THE STATE OF MICHIGAN

If you are a resident of the state of Michigan, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Michigan. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

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

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

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1. The ***ELIGIBILITY*** section, ***ELIGIBILITY, ENROLLMENT AND TERMINATION INFORMATION*** section, ***WHO GETS BENEFITS*** section, or similar section in your Benefit Booklet describing who is eligible to receive **benefits**, is amended to include the following:

   **a. Coverage During Leave of Absence from School**
   Coverage will continue for a **dependent child** who is a full-time or part-time student and takes a leave of absence from school due to illness or injury, so long as the student remains otherwise eligible for coverage under the group contract. Coverage will continue for twelve (12) months from the last day of attendance in school or until the **dependent** reaches the age at which coverage would otherwise terminate, whichever period is shorter.

   In order to qualify for the medical leave of absence, the **dependent** student's attending **physician** will certify in writing to us that it is **medically necessary** for the **dependent** student to take a leave of absence from school.

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

**Effective Date of Rider: January 1, 2026, or the date on which your coverage begins under the group contract, whichever is later.**

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## RIDER FOR RESIDENTS OF THE STATE OF MISSISSIPPI

If you are a resident of the state of Mississippi, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Mississippi. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

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

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

1. The ***COVERED SERVICES*** section, or similar section in your Benefit Booklet describing your covered **benefits**, is amended to include the following **benefit**:

   **a. Temporomandibular Joint Disorder and Craniomandibular Disorder Coverage**
   Coverage for diagnostic and surgical treatment of temporomandibular joint disorder and craniomandibular disorder will be the same as that for treatment to any other joint in the body. Coverage applies to treatment administered or prescribed by a **physician** or dentist.

2. The ***OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS*** section, ***OUTPATIENT DRUGS AND MEDICINES PROGRAM*** section, ***PHARMACY BENEFITS*** section, or similar section in your Benefit Booklet describing your prescription drug **benefits**, is amended to include the following **benefit**:

   **a. Prescription Drug Program Cash Discount Cards Prohibition**
   We will not issue or distribute any **cash discount card** that participating pharmacies must accept or honor as a condition or requirement of participation in the **prescription drug program**. Participating pharmacies that honor or accept prescription drug program identification cards will only honor or accept these discounts if we pay a portion of the cost of the discount given by the **pharmacy** for prescriptions purchased with the use of the **cash discount card**

   **Prescription drug program** means a program or plan that provides coverages and benefits for prescription drugs for members or participants in the program, whether the program is a separate program or part of a health benefit plan.

   **Cash discount card** means a card, other than the program identification card of a member or participant of a prescription drug program, that allows the holder to obtain a discount on a prescription drug when paying for the prescription at the point-of-sale

3. The ***GENERAL PROVISIONS*** section, or similarly named section in your Benefit Booklet is amended to include the following provisions:

   **a. Continuation Privilege**
   If you are covered under the group contract and your employment or membership terminates, you may continue your coverage for yourself and eligible **dependents**. Continuation will be available for a **participant** who has been continuously insured under the group contract, or for similar **benefits** under any other group contract that it replaced, during the period of three (3) consecutive months immediately before the date of termination. The continued policy must cover all dependents covered under the group contract.

   A **dependent** spouse may elect continuation of dependent spouse and dependent child coverage for a period not to exceed twelve (12) months after:
   - The date of death of the employee or member
   - The date of the spouse's divorce from the employee or member
   - The date that the employee or member becomes entitled to Medicare benefits

   A **dependent child** of an employee or member may elect continuation of coverage for a period not to exceed twelve (12) months after the **child** ceases to be an eligible **dependent**.

Continuation will not be available to any **participant** if:

- The **participant** is eligible for other coverage within thirty-one (31) days of the date of termination
- The coverage was terminated due to fraud or non-payment
- The **participant** is eligible for continuation under COBRA
- The **participant** is entitled to **benefits** under Medicare.

Continuation will not include dental, vision care or any other **benefits** provided under the group policy in addition to its **hospital**, surgical or major medical **benefits**.

A **participant** choosing continuation must submit a written election form and meet the following requirements:

- Payment of the full group rate due in advance. This rate cannot exceed the standard group rate applicable to the **participant** under the group contract
- Payment of the first contribution on or before the date on which the **participant's** insurance would otherwise terminate
- Payment of premiums at least monthly

**b. Additional Continuation for Certain Dependents**

We will also provide notice of continuation privilege to certain eligible **dependents** within fourteen (14) days of any of the following:

- the notification by the **participant** of the ineligibility of a **dependent child**
- the notification by the **participant** or spouse of their divorce
- the death of the **participant**

Eligible individuals have thirty (30) days after the notice to elect continuation of coverage.

**c. Continuation Privilege Termination**

Continuation of coverage for any **participant** will terminate on the earliest of the following dates:

- The date twelve (12) months after the date the **participant's** insurance under the policy would otherwise have terminated because of termination of employment or membership.
- The date ending the period for which the **participant** last makes their required contribution, if they discontinue their contributions.
- The date the **participant** becomes or is eligible for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured.
- The date on which the group contract is terminated or, in the case of a multiple employer plan, the date the contractholder terminates participation under the group master policy.

- The date a surviving spouse or former spouse of the participant remarries and becomes covered under a group health plan that does not exclude coverage for preexisting conditions.
- The date the **participant** becomes entitled to benefits under Medicare.

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

**Effective Date of Rider: January 1, 2026, or the date on which your coverage begins under the group contract, whichever is later.**

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**Brian Snell,**
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## RIDER FOR RESIDENTS OF THE STATE OF RHODE ISLAND

If you are a resident of the state of Rhode Island, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Rhode Island. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater benefits will be in effect.

The following terms are used in this Rider:

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or **group contract**.

"**Participant**" means "participant", "covered person", "insured person", "insured member", "subscriber", "beneficiary member", "Member", or your "**dependent**" as may be defined in your Benefit Booklet.

"**Group contract**" means "group policy", "group contract", or "contract", as defined in your Benefit Booklet.

"**Group contractholder**" "group policyholder", "group administrator", or "group contractholder", as may be defined in your Benefit Booklet.

"You" or "your" means the insured employee or insured member of the contractholder who is covered under the **group contract**.

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

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

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**1**. The ***OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS*** section, OUTPA***TIENT DRUGS AND MEDICINES*** **PROGRAM** section, ***PHARMACY BENEFITS*** section, or similar section in your Benefit Booklet describing your prescription **benefits**, is amended to include the following:

**a. Orally Administered Anticancer Medication – Cost-Sharing Requirement**
If your group contract covers intravenously administered or injected cancer medications under the medical benefits section, prescribed orally administered anticancer medications, which are used to kill or slow the growth of cancerous cells, will be covered on a basis no less favorable than intravenously administered or injected cancer medications.

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

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## RIDER FOR RESIDENTS OF THE STATE OF SOUTH CAROLINA

If you are a resident of the state of South Carolina, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of South Carolina. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

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

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

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1. The ***ELIGIBILITY*** section, ***ELIGIBILITY, ENROLLMENT AND TERMINATION INFORMATION*** section, ***WHO GETS BENEFITS*** section, or similar section in your Benefit Booklet describing who is eligible to receive **benefits**, is amended to include the following:

   **a. Continued Coverage of Dependent Children**
   Coverage for your unmarried **dependent child** may continue under the group contract beyond the age of twenty-six (26) if your **dependent child** is:
   - Incapable of self-sustaining employment by reason of intellectual disability or physical disability, and
   - Chiefly dependent upon you for support and maintenance

   Proof of such incapacity and dependency must be provided within thirty-one (31) days of the **child's** attainment of the limiting age. After the two-year period following your **child's** attainment of the limiting age, we may require proof satisfactory to us, of the continuance of such incapacity and dependency but no more frequently than annually.

   **b. Medically Necessary Leave of Absence for Dependent Children**
   A **dependent child** undergoing a **medically necessary leave of absence** from a postsecondary educational institution **is entitled to the same benefits** during this approved absence.

   Any **medically necessary leave of absence** for a **dependent child** requires written certification by a treating **physician** of the **dependent child** stating the **child** is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is **medically necessary**.

   In the case of a **dependent child** we will not terminate coverage of the **child** due to a medically **necessary leave** of absence before the date that is the earlier of either:
   - One year after the first day of the **medically necessary leave of absence**
   - The date on which the coverage would otherwise terminate under the terms of the group contract

   **Medically necessary leave of absence** means a leave of absence of a **dependent child** from a postsecondary educational institution, including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965, or any other change in enrollment of the **child** at such an institution. Any leave of absence must:
   - Commence while the **child** is suffering from a serious illness or injury
   - Be **medically necessary**
   - Cause the **child** to lose student status for purposes of coverage under the terms of the group contract

**c) Eligibility to Enroll**

We may not establish rules for eligibility based on any of the following health status- related factors in relation to the individual or a **dependent** of the individual:

- Health status
- Medical condition, including physical and mental illnesses
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Disability

As a condition of enrollment or continued enrollment under the group contract, no individual or **dependent** enrolled is required to pay a premium or contribution greater than the premium or contribution for a similarly situated **participant** on the basis of any health status-related factor.

2. The ***COVERED SERVICES*** section, or similar section in your Benefit Booklet describing your covered **benefits**, is amended to include the following **benefits**:

**a. Mental Health Benefits**

If your group contract does not include an annual limit on medical and surgical **benefits**, we may not impose any annual limit on mental health or substance use disorder **benefits**.

If your group contract provides coverage for medical or surgical **benefits** provided by **out-of-network providers**, we will provide coverage for mental health or substance use disorder **benefits** provided by **out-of-network providers**.

3. The ***CLAIM FILING AND APPEALS PROCEDURES*** section, ***HOW TO FILE A CLAIM*** section, or similar section in your Benefit Booklet describing claims and appeals, is amended to include the following:

**a. Notice of Claim**

Written notice of claim must be given to us within twenty (20) days after the occurrence or start of the loss on which the claim is based. If notice is not given in that time, the claim will remain valid if it can be shown that notice was not possible and that notice was given as soon as reasonably possible.

**b. Claim Forms**

Upon receipt of your notice of claim, we will provide you or the contractholder with claim forms for filing proof of loss. If the claim forms are not provided within fifteen (15) days after we receive the notice of claim, the person making the claim is considered to have complied with the requirements of the group contract as to proof of loss if they have submitted written proof covering the occurrence, character, and extent of the loss within the time stated in the Proof of Loss provision.

**c. Proof of Loss**

Written proof of loss of time for disability must be provided to us within ninety (90) days after the start of the period for which we are liable. Future written proofs of the continuance of the disability must be provided to us upon request. Written proof of any other loss must be provided to us within ninety (90) days after the date of loss. Failure to provide proof within the time required will not cause a claim to be invalidated or reduced if it was not reasonably possible to provide such proof and it was provided as soon as reasonably possible. Proof must be submitted no later than one (1) year from the time proof is otherwise required unless you are legally incapacitated.

**d. Time of Payment of Claims**

**Benefits** payable will be paid no more than sixty (60) days after the receipt of proof of loss.

4. The ***GENERAL PROVISIONS*** section, or similarly named section in your Benefit Booklet, is amended to include the following:

**a. Grounds for nonrenewal or discontinuation of coverage**

Cancellation or discontinuance of coverage can only occur in the event of one or more of the following:

- Your contractholder has failed to pay premiums or contributions in accordance with the terms of the coverage
- We have not received timely premium payments
- Your contractholder has performed an act of fraud or made an intentional misrepresentation of fact under the terms of the coverage
- You, or an individual acting as your representative, has fraudulently or intentionally misrepresented a person's prior health condition. In this instance, we reserve the right to deny coverage or to impose as a condition of continued coverage the exclusion of the condition misrepresented
- Your contractholder has failed to comply with participation or contribution rules

- We cease to offer coverage in the market
- There are no longer any enrollees living, residing or working within the **service area**

**b. Discontinuation of Coverage**

If we decide in any case to discontinue offering all health insurance coverage we must do both of the following:

- Notify the Director of Insurance, the contractholder and all **participants** at least one hundred and eighty (180) days before the date of discontinuation
- Discontinue all coverage and renewals issued in the state

**c. Grace Period**

The contractholder is entitled to a grace period of thirty-one (31) days for each premium payment after the first premium. Coverage will remain in force during the grace period unless the contractholder has provided us with a written notice requesting termination of coverage in advance of the date of termination in accordance with the terms of the group contract. The contractholder is liable for the payment of a pro rata premium for the time the group contract was in force during the grace period. Any valid claims for covered losses received prior to the end of the grace period will be covered.

**d. Incontestability**

Except for fraudulent misstatements made by a person covered under your group contract:

- The validity of your group contract may not be contested after it has been in force for two (2) years after its date of issue
- No statement made by any **participant** under the group contract relating to insurability may be used in contesting the validity of coverage:
    - After the coverage has been in force for two (2) years before the questioning of the coverage
    - Unless the statement is provided in writing signed by the participant making the statement

**e. Legal Action**

No legal action may be brought to recover under the group contract within sixty (60) days after written proof of loss has been filed as required and no such action may be brought at all unless brought within six (6) years from the time proof of loss is required to be provided.

**f. Continuation Privilege**

Any **participant** continuously covered for at least six (6) months whose coverage has been terminated for any reason other than nonpayment of premiums, is entitled to continuation of coverage for the remainder of the month in which they are terminated plus an additional six (6) months. Continuation of coverage is subject to the group contract, or a successor policy remaining in force and the **participant** paying the entire premium, including any portion usually paid by the former **employer**, before the date each month that the group policy month begins.

If a **participant** is covered under a right of continuation but also covered under another health care plan, that other health care plan will be primary. Benefits paid under the continuation privilege will be secondary.

A **participant** is not entitled to continuation of coverage if:

- Eligible for other group coverage which provides similar **benefits**
- Eligible for Medicare **benefits**

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# RIDER FOR RESIDENTS OF THE STATE OF TEXAS

If you are a resident of the state of Texas, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Texas. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "**dependent**" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

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

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1. The ***COVERED SERVICES*** section, or similar section in your Benefit Booklet describing your covered **benefits**, is amended to include the following:

    **a. Temporomandibular Joint Treatment**

    **Covered services** include diagnostic or surgical treatment of conditions affecting the temporomandibular joint as a result of:

    - An accident
    - A trauma
    - A congenital defect
    - A developmental defect
    - A pathology

    - "Temporomandibular joint" includes the jaw and the craniomandibular joint.

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

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