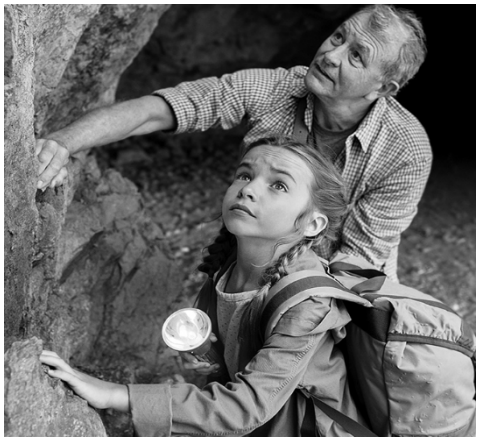
BlueCross BlueShield of Illinois

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



Your Health Care Benefits Program

300 East Randolph Street | Chicago, IL 60601-5099

1-800-892-2803

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BENEFIT HIGHLIGHTS

Plan Name: Blue Precision Silver HMO 102 - Rx Copays

Network Name: Blue Precision HMO℠

Your health care benefits are highlighted below. However, it is necessary to read this entire Certificate to obtain a complete description of your benefits. However, to fully understand your benefits, it is very important that you read this entire Certificate. The Deductible shall not apply unless otherwise specified in the benefits described below.

OVERALL PROGRAM DEDUCTIBLE
(not all expenses will apply to the deductible)

Your Individual Coverage Deductible*	$7,100 per Calendar Year
Your Family Coverage Deductible*	$17,200 per Calendar Year

PHYSICIAN BENEFITS

NOTE: Covered Services for sterilization procedures are covered at no cost to you when the services are ordered by your Primary Care Physician or Woman's Principal Health Care Provider.

Your Cost for Covered Services (unless specified otherwise below)	None
Your Cost for Outpatient Office Visits	$65 per Visit
Your Cost for Outpatient Specialist Physician Visits	$95 per Visit
Your Cost for Outpatient Diagnostic Services	$125 per Procedure
Your Cost for Outpatient Surgery	$100 per Visit
Your Cost for Outpatient CT Scans, PET Scans and MRIs	$400 per Procedure
Your Cost for Outpatient Office Visits for Preventive Care Services	None
Your Cost for Outpatient Physical, Occupational and Speech Therapy Treatments	$125 per Visit
Your Cost for Outpatient Office Visits for the Treatment of Mental Illness	$65 per Visit
Chiropractic and Osteopathic Manipulation Maximum	25 Visits per Calendar Year

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Telehealth and Telemedicine	
Your Cost for Outpatient Visits	$65 per Visit
Your Cost for Outpatient Visits for the treatment of Mental Illness	$65 per Visit
Your Cost for Outpatient Visits for the Treatment of Substance Use Disorder	$65 per Visit
Your Cost for Outpatient Specialist Physician Visits	$95 per Visit

HOSPITAL BENEFITS

Your Cost for Inpatient Covered Services	$400 Inpatient Copayment per Visit then 30% Coinsurance, after deductible
Your Cost for Inpatient Office Visits for the Treatment of Mental Illness	$400 Inpatient Copayment per Visit, then 30% Coinsurance, after deductible
Your Cost for Outpatient Surgery	$350 per Visit, then 30% Coinsurance after deductible
Your Cost for Urgent Care	$95 per Visit
SUPPLEMENTAL BENEFITS	
Your Cost for Covered Services	30% Coinsurance, after deductible

EMERGENCY CARE BENEFITS

Hospital Emergency Care

Your Cost for an In-Area or Out-of-Area Emergency	30% Coinsurance, after deductible
Emergency Room	$700 Copayment per Visit,after deductible (waived if admitted to Hospital as an Inpatient immediately following emergency treatment)
Your Cost for Emergency Ambulance Transportation	30% Coinsurance, after deductible

SUBSTANCE USE DISORDER TREATMENT BENEFITS

Your Cost for an Inpatient Substance Use Disorder Treatment	$400 per Visit, then 30% Coinsurance, after deductible
Your Cost for Outpatient Office Visits for Substance Use Disorder Treatment	$65 per Visit
Your Cost for Outpatient Specialist Physician Visits for Substance Use Disorder Treatment	$65 per Visit

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OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

You may receive coverage for up to a 12-month supply for dispensed contraceptives. Certain contraceptive drugs may be available at no cost to you. Please see the **OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION** of your Certificate, for additional information.

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 contraceptives drugs and products will be provided as shown below.

If you or your Provider Requests a Brand Name Drug when a generic 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 generic or therapeutic equivalent, except as otherwise provided in your 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).

Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider participating in the 30-Day Supply Prescription Drug Program after you have met your program deductible (if applicable):	
Tier 1	$5 per prescription
Tier 2	$15 per prescription
Tier 3	$60 per prescription
Tier 4	$110 per prescription
Tier 5	$250 per prescription
Tier 6	$350 per prescription
The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $35, when obtained from a Participating Pharmacy. The amount you may pay for a twin pack of Medically Necessary epinephrine injectors, regardless of type, shall not exceed $60, when obtained from a Participating Pharmacy.	
Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider **not** Participating in the 30-Day Supply Prescription Drug Program:	
The appropriate Copayment Amount(s) indicated above for drugs prescribed for emergency conditions.	
Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Participating Prescription Drug Provider participating in the 90-Day Supply Prescription Drug Program: Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	
Tier 1	$15 per prescription
Tier 2	$45 per prescription
Tier 3	$180 per prescription
Tier 4	$330 per prescription
Tier 5	$750 per prescription
Tier 6	$1,050 per prescription

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No benefits will be provided for drugs or diabetic supplies purchased from a Preferred or a Participating Prescription Drug Provider **not** participating in the 90-day supply program.

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 member cost share, to make these medications more affordable to members.

PEDIATRIC DENTAL BENEFITS

Your Cost for Covered Pediatric Dental Care Services from a Participating Dentist:

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 except for Preventive Dental Services.

Diagnostic Evaluations	30% Coinsurance
Preventive Dental Services	None
Diagnostic Radiographs	30% Coinsurance
Miscellaneous Preventive Dental Services	None
Basic Restorative Dental Services	30% Coinsurance
Non-Surgical Extractions	30% Coinsurance
Non-Surgical Periodontal Services	30% Coinsurance
Adjunctive Services	30% Coinsurance
Endodontic Services	30% Coinsurance
Oral Surgery Services	30% Coinsurance
Surgical Periodontal Services	30% Coinsurance
Major Restorative Services	30% Coinsurance
Prosthodontic Services	30% Coinsurance
Miscellaneous Restorative and Prosthodontic Services	30% Coinsurance
Orthodontic Dental Services	30% Coinsurance
Implant Placement Surgery	30% Coinsurance

HEARING AID BENEFITS

Hearing Aids

Benefit Period	24 months
Your Cost for a Hearing Aid	30% Coinsurance, after your program deductible
Benefit Maximum for Hearing Aids	None
Number of Hearing Aids, per ear, each benefit period	One

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COVERED SERVICES EXPENSE LIMITATION

Refer to the **OTHER THINGS YOU SHOULD KNOW** section of your Certificate for information regarding Covered Services Expense Limitation. (not all expenses will apply to the deductible)

Individual Coverage Out-of-Pocket Expense Limitation	$10,000** per Calendar Year
Family Coverage Out-of-Pocket Expense Limitation	$20,000** per Calendar Year
LIMITING AGE FOR DEPENDENT CHILDREN	26 (Please refer to the ELIGIBILITY section of this Certificate)

* The deductible amount is subject to change or increase as permitted by applicable law or regulatory guidance
** This limit is subject to change or increase as permitted by applicable law or regulatory guidance and does not apply to all services

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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 Care Provider** (When a fixed dollar Copayment is due from the member, the remainder is payable by the plan up to the Covered Charge*)
Exam: (with dilation as necessary; routine eye examinations do not include professional services for Contact Lenses)	No Copayment
"Provider-designated" Frames Frames covered under 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 under the Certificate.	No Copayment
Frequency: Examination, Lenses, or Contact Lenses Frame	Once every 12-month benefit period
Standard Plastic, Glass, or Polycarbonate Spectacle Lenses: Single Vision Bifocal Trifocal Lenticular Standard Progressive Lens	 No Copayment No Copayment No Copayment No Copayment No Copayment
Lens Options (add to lens prices above): UV Treatment Standard Plastic Scratch Coating Standard Polycarbonate Photocromatic/Transitions Plastic	No Copayment
Contact Lenses: (Contact Lens allowance includes materials only) Elective - Extended Wear Disposables Daily Wear/Disposable Conventional	100% coverage for provider-designated Contact Lenses Up to 6-months supply of monthly or 2-week disposable, single vision spherical or toric Contact Lenses. Up to 3-months supply of daily disposable single vision spherical Contact Lenses. 1 pair from selection of provider-designated Contact Lenses
Medically Necessary Contact Lenses – preauthorization is required	No Copayment, Paid-In-Full
Non-Participating Vision Care Providers:	Not covered
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.	
Value-added features: **Laser vision correction:** You will receive a discount for traditional LASIK and custom LASIK from participating Physicians and affiliated laser centers. You must obtain Preauthorization for this service. *Prices/discounts may vary by state and are subject to change without notice.*	

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Additional Benefits
Medically Necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, posttraumatic disorders, irregular astigmatism. 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. Covered low vision services will include one comprehensive low vision evaluation every 5 years for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period. Participating providers will obtain the necessary preauthorization for these services.
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 Providers for a particular Covered Service.

The Plan pays the lesser of the allowance noted or the retail cost. Retail prices vary by location.

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

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

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

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

This Certificate is currently certified as a Qualified Health Plan.

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

If you have any questions once you have read this Certificate, talk to your Group Administrator or call us at your local Blue Cross and Blue Shield of Illinois 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 to you our best service.

Sincerely,

Blue Cross and Blue Shield of Illinois

A Division of Health Care Service Corporation

A Mutual Legal Reserve Company

Brian Snell, President Illinois Division

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ELIGIBILITY

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

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

1. Meet the definition of Eligible Person as specified in the Group Policy; and
2. Have applied for this coverage; and
3. Have received a Blue Cross and Blue Shield of Illinois identification card; and
4. Live within the service area of Blue Cross and Blue Shield of Illinois. (Contact your Group or Customer Service at 1-800-892-2803 for information regarding service area.); and
5. Reside, live or work in the geographic Network Service Area served by Blue Cross and Blue Shield of Illinois 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.
6. If Medicare eligible, have both Part A and B coverage.

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

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

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

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

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

APPLYING FOR COVERAGE

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

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

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

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

A Tobacco User may be subject to a premium increase 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 the Plan 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 and/or Dependents during one of the following enrollment periods. Your and/or your eligible spouse and/or Dependents' effective date will be determined by the Plan depending upon the date your application is received and other determining factors.

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

Annual Open Enrollment Periods/Effective Date of Coverage

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

When you enroll during the annual open enrollment period, your and/or your eligible Dependents effective date will be the following January 1, unless otherwise designated by the Plan, as appropriate.

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

SPECIAL ENROLLMENT PERIODS

Special Enrollment Periods/Effective Dates of Coverage

Special enrollment periods have been designated during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or Dependents. You must apply for or request a change in coverage within 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 section. 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. The Plan will review this proof to verify your eligibility for a special enrollment. Failure to provide acceptable proof of a qualifying event with your application will delay or prevent the processing of your application and enrollment in coverage. Please call the Customer Service number on the back of your identification card or visit our website at *www.bcbsil.com* for examples of acceptable proof for the following qualifying events.

Special Enrollment Events:

1. You gain or lose a Dependent or become a Dependent through marriage, 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 and/or Dependents will be effective no later than the 1st day of the following month.
2. You gain a Dependent through birth, placement of a foster child, adoption or placement of adoption or court-ordered Dependent coverage. New coverage for you and/or your eligible spouse, party to a Civil Union or Domestic Partner,

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provided your employer covers Domestic Partners, and/or Dependents will be effective on the date of the birth, placement of a foster child, adoption, or placement of adoption. However, the effective date for court-ordered eligible child coverage will be determined in accordance with the provisions of the court-order.

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

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

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

Other Special Enrollment Events/Effective Dates of Coverage:

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 section.

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 plan 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 Dependent's coverage (excluding COBRA continuation coverage).
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 the Plan. Your spouse, party to a Civil Union or Domestic Partner (provided your employer covers Domestic Partners) and other Dependents are not eligible for a special enrollment period if the Group does not cover Dependents.

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

NOTIFICATION OF ELIGIBILITY CHANGES

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

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

Under Family Coverage, your health care expenses and those of your enrolled spouse and your (and/or your spouse's) enrolled children who are under the limiting age specified in the **BENEFIT HIGHLIGHTS** section of this Certificate will be covered. All of the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union. A Domestic Partner and his or her children who have not attained the limiting age specified in the **BENEFIT HIGHLIGHTS** section of this Certificate may also be eligible Dependents, provided your employer covers Domestic Partners. All of the provisions of this Certificate that pertain to a spouse 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), adopted child(ren), foster child(ren), a child(ren) of your 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 of the Plan network for this Certificate; and
2. Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
3. Have received a release or discharge other than a dishonorable discharge.

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

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

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

Any children who are incapable of self-sustaining employment and are Dependent upon you or other care Providers for lifetime care and supervision because of a 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.

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

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

MEDICARE ELIGIBLE ENROLLEES

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 or 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 the Plan and/or your employer regarding the Medicare eligibility of you, your spouse and covered Dependent children. In addition, if you, your spouse or covered Dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your Group Administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

YOUR IDENTIFICATION CARD

You will receive an identification (ID) card from the Plan. Your ID card contains your identification number. 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

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

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If the Plan terminates your coverage under this Certificate for any reason, the Plan will provide you with a notice of termination of coverage that includes the termination effective date and the reason for termination at least 30 days prior to the last day of coverage, or such other notice, if any, permitted by applicable law 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 is specified by you, if you provide reasonable notice.
2. When the Plan does not receive the full amount of the premium payment or other charge or amount on time or when there is a bank draft failure of premiums for your and/or your eligible spouse, party to a Civil Union or Domestic Partner and/or Dependents' coverage and the grace period, if any, has been exhausted.
3. You no longer live, reside or work in the Plan's service area or live, reside or work in the Network Service Area.
4. In the case of intentional fraud or material misrepresentation.

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

Cancellation of your coverage under this Certificate terminates the coverage of all your Dependents under this Certificate. Benefits will not be provided for any services or supplies received after the date coverage terminates under this Certificate, unless specifically stated otherwise in this Certificate or below under the heading “Extension of Benefits in Case of Discontinuance of Coverage”. However, termination of your coverage will not affect your benefits for any services or supplies that you received prior to your termination date.

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

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 him/her 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 the **BENEFIT HIGHLIGHTS** section of this Certificate.

WHO IS NOT ELIGIBLE

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

This section **“WHO IS NOT ELIGIBLE”** is subject to change by the Plan and/or applicable law, 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. These benefits are subject to all the terms and conditions of this Certificate including, but not limited to, the requirements regarding Primary Care Physician referral. It is your responsibility to notify the Plan, and to provide, when requested by the Plan, written documentation of your disability.

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This extension of benefits does not apply to the benefits provided in the Outpatient Prescription Drug Program Benefits of this Certificate.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

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 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 his or her 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:

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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 his or her 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.”

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

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

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Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

COVERAGE AFTER TERMINATION (Illinois State Laws)

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

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

ARTICLE A: Continuation coverage if you are the Eligible Person

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If an Eligible Person's coverage under this Certificate should terminate because of termination of employment or membership or because of a reduction in hours below the minimum required for eligibility, an Eligible Person will be entitled to continue the Hospital, Physician and Supplemental coverage provided under this Certificate for himself/herself and they are eligible Dependents (if they had Family Coverage on the date of termination). However, this continuation coverage option is subject to the following conditions:

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

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

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

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

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

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

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

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

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

If the coverage of the spouse of an Eligible Person should terminate because of the death of the Eligible Person, a divorce from the Eligible Person, dissolution of a Civil Union from the Eligible Person, or the retirement of an Eligible Person, the former spouse or retired Eligible Person's spouse if at least 55 years of age, will be entitled to continue the coverage provided under this Certificate for himself/herself and their eligible Dependents (if Family Coverage is in effect at the time of termination). However, this continuation coverage option is subject to the following conditions:

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

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

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

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

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

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

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

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

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

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

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

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

7. Termination of Continuation Coverage:

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

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

   b. On the date coverage would otherwise terminate under this Certificate if you were still married to or in a Civil Union with the Eligible Person; however, your coverage shall not be modified or terminated during the

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first 120 consecutive days following the Eligible Person's death or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to the Plan of the death of the Eligible Person or of the Dependent child reaching the limiting age, as well as notice of the Dependent child's address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, the Plan

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will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. The Plan's notice to you will include the following:

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

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

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

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

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

6. The monthly charge will be computed as follows:

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

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

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

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

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

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

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

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

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

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

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

CONTINUATION COVERAGE FOR PARTIES TO A CIVIL UNION

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

Continuation Coverage

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

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

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

CONTINUATION COVERAGE FOR DOMESTIC PARTNERS

The purpose of this provision of your Certificate is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this Certificate as the 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 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 to a Dependent child as described in the **CONTINUATION COVERAGE AFTER TERMINATION (Illinois State Laws)** provision of this Certificate are available to you, if applicable to your Group. In addition, coverage similar to the options described in the **CONTINUATION COVERAGE RIGHTS UNDER COBRA** provision of this Certificate will also be available to you.

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

In addition to the events listed in **the CONTINUATION COVERAGE RIGHTS UNDER COBRA** provision and the **CONTINUATION COVERAGE AFTER TERMINATION (Illinois State Laws)** provision, if applicable, continuation coverage is available to you and your eligible spouse, party to a Civil Union, Domestic Partner and/or Dependent children in the event you lose coverage because your 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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YOUR PRIMARY CARE PHYSICIAN

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

As a participant in this benefit program, a directory of Participating Individual Practice Associations (IPAs)/or Participating Medical Groups are available to you. For more information or for a list of Participating IPAs/or Participating Medical Groups. you may contact Customer Service at the toll-free telephone number on the back of your identification card, or visit the Plan's website at www.bcbsil.com.

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

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

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

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

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

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

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

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

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

Changing Your Participating IPA/Participating Medical Group

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

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

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

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

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

Changing Your Woman's Principal Health Care Provider

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

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

After-Hours Care and When Your PCP/WPHCP is Not Available

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

Transition of Care Benefits

If you are a new HMO Enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy, and your Physician does not belong to the Plan's network, but is within the Plan's service area, you may request the option of transition of care benefits. You must submit a written request to the Plan for transition of care benefits within 15 business days of your eligibility effective date. The Plan may authorize transition of care benefits for a period of up to 90 days from the effective date of enrollment. Authorization of

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benefits is Dependent on the Physician’s agreement to contractual requirements and submission of a detailed treatment plan. A written notice of the Plan’s determination will be sent to you within 15 business days of receipt of your request.

If you are a current HMO Enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy and your Primary Care Physician or Woman's Principal Health Care Provider leaves the Plan's network, you may request the option of continuity of care benefits as described in the Continuity of Care provision in the **OTHER THINGS YOU SHOULD KNOW** section. You must submit a written request to the Plan for continuity of care benefits within 30 business days after receiving notification of your Primary Care Physician or Woman's Principal Health Care Providers termination. Such termination notification will be provided within 60 days of your Primary Care Physician or Women’s Principal Health Care Provider leaving the network (for reasons other than terminations in situations involving direct imminent physical harm to a patient or a final disciplinary action by State licensing board).

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

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

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YOUR OVERALL PROGRAM DEDUCTIBLE

If you have Individual Coverage, each calendar year you must satisfy the program deductible amount(s) shown in the **BENEFIT HIGHLIGHTS** section of this Certificate before receiving benefits, if any.

If you have Family Coverage and your family has satisfied the program deductible amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate, if any, it will not be necessary for anyone else in your family to meet a deductible in that calendar year. That is, for the remainder of that calendar year, no other family members will be required to meet the calendar year deductible before receiving benefits.

When your Group initially purchased this coverage, if you were a member of the Group at that time you are entitled to a special credit toward your program deductible 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 program deductible 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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PHYSICIAN BENEFITS

This section lists the Covered Services under your Certificate. **Please note that services must be determined to be Medically Necessary by the Plan in order to be covered under this Certificate.**

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

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

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

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

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

Your coverage includes benefits for the following Covered Services:

Anesthesia – Benefits are available for Medically Necessary anesthesia services, regardless of duration, if administered in connection with a covered surgical procedure by a Physician, Dentist or Podiatrist other than the operating surgeon or by a Certified Registered Nurse Anesthetist.

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

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

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

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

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.

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

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.

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

Breast Reduction Surgery – This plan provides benefits for Medically Necessary breast reduction surgery.

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

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

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

b. It manifested before the age of 22.

c. It is likely to continue indefinitely; and

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

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

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.

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.

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

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

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

If a routine mammogram reveals heterogeneous or dense breast tissue, or when determined to be Medically Necessary by your Primary Care Physician, Woman's Principal Health Care Provider, Advanced Practice Nurse Physician, Advanced Practice Nurse, or Physician Assistant, benefits will be provided for a comprehensive ultrasound screening, molecular breast imaging (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 your Primary Care Physician, Woman's Principal Health Care Provider, Advanced Practice Nurse, or Physician's Assistant.

Benefits for mammograms will be provided with No Cost Share, whether or not you have met your program deductible and will not be subject to any Benefit Period maximum or lifetime maximum.

Surgery – when performed by a Physician, Dentist or Podiatrist or other Provider acting within the scope of their license. However, benefits for oral Surgery are limited to the following services:

1. Surgical removal of completely bony impacted teeth.
2. Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth.
3. Surgical procedures to address major injuries of the jaws, cheeks, lips, tongue, roof 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:

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

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Medical Care

Benefits will be provided for Medical Care rendered to you:

1. When you are an Inpatient in a Hospital, Skilled Nursing Facility or a Residential Treatment Center.
2. When you are a patient in a Home Health Care Program; or
3. On an Outpatient basis in your Physician's office or your home.

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

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

Preventive Care Services

In addition to the benefits otherwise provided in this Certificate, (and notwithstanding anything in your Certificate to the contrary), the following preventive care services will be considered Covered Services when delivered by a Primary Care Physician, Woman's Principal Health Care Provider, or another Physician who is affiliated with your Participating IPA/ Participating Medical Group and Participating Pharmacy Provider, and will not be subject to any deductible, Coinsurance, Copayment or benefit dollar maximum when implemented in the quantities and within the time period allowed under applicable law or regulatory guidance:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”).
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved.
3. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
4. With respect to individuals, such additional preventive care and screenings, not described in item 1. above, as provided for in comprehensive guidelines supported by the HRSA.

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

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

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Plan’s website at www.bcbsil.com or contact Customer Service on 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 for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment for the office visit including the preventive health service.

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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. Unhealthy alcohol use screening and counseling.
3. Aspirin use for men and women for prevention of cardiovascular disease for certain ages.
4. Blood pressure screening.
5. Cholesterol screening for adults of certain ages or at higher risk.
6. Colorectal cancer screening for adults over age 45.
7. Depression screening.
8. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease.
9. HIV screening for all adults at higher risk.
10. HIV pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition, including baseline and monitoring services.
11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    a. COVID-19.
    b. Diphtheria, Pertussis, Tetanus (DTap/Tdap/Td).
    c. Haemophilus influenzae type b (Hib).
    d. Hepatitis A.
    e. Hepatitis B.
    f. Herpes Zoster (Shingles).
    g. Human papillomavirus.
    h. Influenza (Flu shot or Flu mist).
    i. Measles, Mumps, Rubella.
    j. Meningococcal.
    k. MPOX.
    l. Pneumococcal.
    m. RSV.
    n. Varicella.
12. Whole body skin examination for lesions suspicious of skin cancer.
13. Obesity screening and counseling.
14. Sexually transmitted infections (STI) counseling.
15. Tobacco use screening and cessation interventions for Tobacco Users.

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16. Syphilis screening for adults at higher risk.
17. Exercise interventions to prevent falls in adults aged 65 years and older who are at increased risk for falls.
18. Hepatitis C virus (HCV) screening for infection in adults aged 18 to 79 years.
19. Hepatitis B virus screening for persons at high risk for infection.
20. Counseling children, adolescents, and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
21. Lung cancer screening in adults 50 and older who have a 20-pack year smoking history and currently smoke or have quit within the past 15 years.
22. Screening for high blood pressure in adults aged 18 years or older.
23. 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) one 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.
24. Tuberculin testing for adults 18 years or older who are at a higher risk of tuberculosis.
25. Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese.
26. Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions.
27. Mental Health Prevention and wellness visit.

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, genetic testing.
3. 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.
4. Breast cancer chemoprevention counseling for women at higher risk.
5. Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Electric breast pumps are limited to one per calendar year. Electric breast pumps received by an Enrollee prior to the first calendar year do not count towards the maximum electric breast pump covered by this Certificate.
6. Cervical cancer screening.
7. Chlamydia infection screening for younger women and women at higher risk.
8. Contraception: Certain FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling.
9. Domestic and interpersonal violence screening and counseling for all women.

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10. Daily supplements of .4 to .8 mg of folic acid for women who may become pregnant.
11. Diabetes screening after pregnancy.
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 all 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. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
19. Tobacco use screening and interventions for all women and expanded counseling for pregnant Tobacco Users.
20. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have been recently screened.
21. Sexually transmitted infections (STI) counseling.
22. Syphilis screening for all pregnant women or other women at increased risk.
23. Well-woman visits to obtain recommended preventive services.
24. Urinary incontinence screening.
25. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence and device removal.
26. Hepatitis C virus (HCV) screening for women at high risk for infection.
27. Aspirin use for pregnant women to prevent preeclampsia.
28. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
29. Perinatal depression screening and counseling.
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. Condoms
33. Menopause health visits.
34. Clinical breast examinations

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

1. Alcohol and drug use assessment for adolescents.

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

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m. Rotavirus.

n. RSV.

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

Covered Services for Outpatient Periodic Health Examinations

Routine pediatric care, women's preventive care (such as contraceptives) and Outpatient periodic health examinations Covered Services not included above will be provided with No Cost Share, whether or not you have met your program deductible, and will not be subject to any Benefit Period maximum or lifetime maximum.

Covered Services include, but are not limited to:

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

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

Preventive Drugs

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 Preventive Services 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 the Plan's 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 deductible, Coinsurance, Copayments or benefit maximums. 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.

Allergy Testing and Treatment

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.

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

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

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

Early Treatment of a Serious Mental Illness

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

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

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

HIV Screening and Counseling – Benefits will be provided for HIV screening and counseling and pre-natal HIV testing ordered by your Primary Care Physician or Women's Principal Health Care Provider, including but not limited to orders

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consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Certificate.

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

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

Massage Therapy – That is, massage to treat muscle pain or dysfunction.

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.

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

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

Prostate Cancer Screening – Benefits will be provided for an annual routine prostate cancer screening.

Radiation Therapy – 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.

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

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.

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

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

Human Papillomavirus Vaccine - Benefits will be provided for a human papillomavirus (HPV) vaccine and a shingles vaccine approved by the federal Food and Drug Administration.

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

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

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

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**.**

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

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.

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 relations to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

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

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

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.

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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 a high risk or showing symptoms of the disease being tested for.

Blood Glucose Monitors for Treatment of Diabetes – This plan provides benefits for Medically Necessary blood glucose monitors (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 Provider.

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

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. Benefits for chiropractic and osteopathic manipulation are limited to 25 visits per calendar year. Chiropractic and Osteopathic Manipulations received by an Enrollee prior to the Enrollee's first calendar year do not count towards the maximum Chiropractic and Osteopathic Manipulation covered by this Certificate.

Cleft Lip and Palate – Benefits will be provided for Medically Necessary treatment and care for cleft lip and palate for children under the age of 19.

Comprehensive Cancer Testing – 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.

Dental Accident Care – Dental services rendered by a Dentist or Physician, limited to sound natural teeth, which are required as the result of an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.

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.

Diabetes Self-Management Training and Education – Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will also be provided for education programs that allow you to maintain a hemoglobin A1c level within the range identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits are also available for Telehealth and Telemedicine Services and regular foot care examinations by a Physician or Podiatrist, and for licensed dietician nutritionists and certified diabetes educators to counsel diabetics in their home to remove the hurdle of transportation for patients receiving treatment. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Certificate.

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.

Experimental/Investigational Treatment – Benefits will be provided for routine patient care in conjunction with Experimental/Investigational treatments when Medically appropriate and you have a terminal condition that according to the

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diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this Certificate if not provided in connection with an Approved Clinical Trial program. You and your Physician are encouraged to call Customer Service at the toll-free number on your identification card in advance to obtain information about whether a particular clinical trial is qualified.

Family Planning Services – Including family planning counseling, prescribing of contraceptive drugs, fitting of contraceptive devices and voluntary sterilization. See Outpatient Contraceptive Services below for additional benefits. Benefits are not available under this benefit section for the actual contraceptive drugs.

Benefits for sterilization procedures will not be subject to any deductible Coinsurance with No Cost Share Copayment when such services are ordered from your Primary Care Physician or Women's Principal Health Care Provider.

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 Medically Necessary treatment may directly or indirectly cause Iatrogenic Infertility to a Covered Person.

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

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

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

Hearing Screening – When done to determine the need for hearing correction.

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

Hearing Aid Benefits –will be provided for Medically Necessary Hearing Aids when a Hearing Care Professional (upon referral from your primary care physician or Woman's Principal Health Care Provider) prescribes a Hearing Aid to augment communications as follows:

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

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

Your Cost for Hearing Aids – Please see the BENEFIT HIGHLIGHTS section of this Certificate for more information regarding the cost for Hearing Aids.

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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.

Please note that benefits may be provided for fertility preservation as set forth in the Fertility Preservation Services provision of this Certificate.

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 renders such treatment useless. Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per calendar year, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered per calendar year. Oocyte retrievals completed prior to the beginning of the plan year do not count towards the maximum retrievals covered by this Certificate.

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

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

Special Limitations

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

1. Services or supplies rendered to a surrogate after eggs, sperm or embryos have been transferred into the surrogate, non-medical expenses you incur to contract with the surrogate, and any other services rendered to a surrogate that are not directly related to treatment of your infertility.
2. Cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance. Please note that benefits may be provided for fertility preservation as set forth in the Fertility Preservation Services provision of this Certificate.
3. Non-medical costs of an egg or sperm donor.
4. Travel costs for travel within 100 miles of the Enrollee's home or which is not Medically Necessary, or which is not required by the Plan.
5. Infertility treatments which are determined to be Investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology.

Immune Gamma Globulin Therapy (IGGT) – Benefits will be provided for immune gamma globulin therapy for covered persons diagnosed with a primary immunodeficiency when prescribed as Medically Necessary by the Primary Care Physician or Woman's Principal Health Care Provider. Nothing shall prevent Blue Cross and Blue Shield or its designee from applying appropriate utilization review standards to the ongoing coverage of IGGT for person diagnosed with a primary immunodeficiency. Subject to such utilization review standards, an initial authorization shall be for no less than three months, and reauthorization may occur every six months thereafter. For persons who have been in treatment for two years, reauthorization shall be no less than every 12 months, unless more frequently indicated by a Physician.

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

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

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)/Pediatric Acute Onset Neuropsychiatric Syndrome (PANS) Treatment – Benefits will be provided for all Medically Necessary treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including coverage for Medically Necessary intravenous immunoglobulin therapy.

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

Pediatric Vision Care – Please see the Pediatric Vision Care Section for more information regarding pediatric vision care benefits.

Pulmonary Rehabilitation Therapy – Benefits will be provided for Outpatient cardiac/pulmonary rehabilitation programs and Outpatient pulmonary rehabilitation services.

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

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

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

Benefits for Outpatient contraceptive services will not be subject to any deductible, Coinsurance with No Cost Share Copayment when such services are ordered from your Primary Care Physician or Women's Principal Health Care Provider.

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 maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
4. The milk has been determined to be Medically Necessary for the infant; and
5. One or more of the following applies:
    a. The infant's birth weight is below 1,500 grams.
    b. The infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
    c. The infant has infant hypoglycemia.
    d. The infant has congenital heart disease.
    e. The infant has had or will have an organ transplant.
    f. The infant has sepsis; or
    g. The infant has any other serious congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the infant.

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

1. The milk is prescribed by a licensed medical practitioner.
2. The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
3. The infant's mother/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 breast milk is contraindicated.

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

5. One or more of the following applies:

   a. The child has spinal muscular atrophy.

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

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

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

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

Temporomandibular Joint Dysfunction

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

Port-Wine Stain Treatment

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

Long-term Antibiotic Therapy

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

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

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.

Mastectomy Related Services

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

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discharge, prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; and 5) the removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic Surgery.

Maternity Services

Your benefits for maternity services are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will be provided for delivery charges and for any of the previously described Covered Services when rendered in connection with pregnancy.

For Family Coverage, benefits will be provided for any treatment of an illness, injury, congenital defect, birth abnormality or a premature birth from the moment of the birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage. Premiums will be adjusted accordingly.

For Individual Coverage, benefits will not be provided for any treatment of an illness or injury to a newborn child unless you have Family Coverage. (Remember you must add the newborn child within 31 days of the date of birth.)

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

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

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

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, the Plan will not provide benefits for such care.

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

Other Reproductive Health Services

Your coverage for abortion care benefits will be provided at no cost. Benefits for abortion care are the same as your benefits for any other condition under this **PHYSICIAN BENEFITS** section.

Telepsychiatry Services

Psychiatric services are covered for the purpose of evaluation and treatment through Telehealth Services if authorized by your Participating IPA/Participating Medical Group or Primary Care Physician/Woman's Principal Health Care Provider. Please refer to the Your Cost for Physician Services provision for additional information.

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Telehealth and Telemedicine Services

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

Tobacco Use Screening and Smoking Cessation Counseling Services

This plan provides benefits for tobacco use screening and smoking cessation counseling services.

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 of Illinois 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 these services 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, including the administration fee, 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-participating 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.

Peripheral Artery Disease Screening

Benefits will be provided for Medically Necessary peripheral artery disease screening for any at-risk individual.

URGENT CARE

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

Your Cost for Urgent Care Treatment

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

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

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family to contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible if Inpatient Hospital care is required.

FOLLOW-UP CARE

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

Your Cost for Follow-Up Care Treatment

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

YOUR COST FOR PHYSICIAN SERVICES

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

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

However, benefits for all other Outpatient office visits, including all related Covered Services received on the same day (except for Outpatient CT scans, PET scans, MRIs, and Outpatient Diagnostic Services) are subject the office visit Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate and then will be paid in full at no cost to you.

Benefits for Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy are subject to the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate per visit, unless otherwise specified in this Certificate, and then will be paid in full at no cost to you.

Benefits for Outpatient Diagnostic Services are subject to the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate per procedure, unless otherwise specified in this Certificate, and then will be paid in full at no cost to you.

Benefits for Outpatient Surgery are subject to the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate per visit, if applicable, and then will be paid in full at no cost to you.

Benefits for all Outpatient CT Scans, MRIs, and PET Scans are subject to the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate per procedure, unless otherwise specified in this Certificate, and then will be paid in full at no cost to you.

Benefits for Outpatient visits to a Specialist Physician's office are subject to the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate per visit and then will be paid in full at no cost to you.

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

1. Physician.

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2. Physician Assistant.
3. Certified Nurse Midwife.
4. Certified Nurse Practitioner.
5. Certified Registered Nurse Anesthetist.
6. Certified Clinical Nurse Specialist; and
7. Marriage and Family Therapist.

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HOSPITAL BENEFITS

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

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

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

COVERED SERVICES

Inpatient Benefits

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

1. **Bed, board and general nursing care** when you are in:
    a. A semi-private room or a private room must be ordered by your Primary Care Physician or Woman's Principal Health Care Provider.
    b. An intensive care unit.
2. **Ancillary services** (such as operating rooms, drugs, surgical dressings and lab work).
3. **Rehabilitative Therapy** (including, but not limited to Physical, Occupational and Speech Therapy).

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

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

Number of Inpatient Days

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

Outpatient Benefits

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

1. **Surgery** – when performed in a Hospital or Ambulatory Surgical Facility. Benefits for Surgery also include Surgery for morbid obesity (including but not limited to bariatric Surgery).
2. **Diagnostic Services** – that is, tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury.
3. **Radiation Therapy** – that is, the use of ionizing radiation in the treatment of a medical illness or condition, including proton beam therapy.
4. **Chemotherapy** – that is, the treatment of malignancies with drugs.
5. **Electroconvulsive Therapy.**
6. **Infusion Therapy.**

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

Special Programs

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

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

Approved Clinical Trials – Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial 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.

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

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

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

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

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

Surgical Implants

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

Maternity Services

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

For Individual Coverage, benefits will not be provided for any treatment of an illness or injury to a newborn child unless you have Family Coverage. (Remember, you must add the newborn child within 31 days of the date of birth.)

Coverage will be provided for the mother/birthing parent and the newborn (if the newborn is added to the family policy) for a minimum of:

1. 48 hours of Inpatient care following a vaginal delivery, or
2. 96 hours of Inpatient care following a delivery by caesarean section, except as may be indicated by the following: A shorter length of Hospital Inpatient stay related to maternity and newborn care may be provided if the attending Physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or by the American Academy of Pediatrics, that the mother/birthing parent and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother/birthing parent and newborn. Such an earlier discharge may only be required if there is coverage and availability of a post-discharge Physician office visit, or an in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, the Plan will not provide benefits for such care.

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

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Other Reproductive Health Services

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

URGENT CARE

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

Your Cost for Urgent Care Treatment

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

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

FOLLOW-UP CARE

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

Your Cost for Follow-Up Care Treatment

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

YOUR COST FOR INPATIENT HOSPITAL SERVICES

The Covered Services of this benefit section are covered in full, with no cost to you, except as shown in the **BENEFIT HIGHLIGHTS** section of this Certificate.

Each time you are admitted as an Inpatient to a Hospital, Skilled Nursing Facility or Residential Treatment Center, you must satisfy the Inpatient Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate. This Copayment is in addition to your program deductible, if applicable. However, if your admission to a Skilled Nursing Facility or Residential Treatment Center immediately follows an Inpatient Hospital stay, then the Copayment will not apply to such admission. After the member pays the applicable Inpatient Copayment, followed by the applicable Coinsurance after the program deductible, you will be responsible for the Coinsurance amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate, if applicable.

YOUR COST FOR OUTPATIENT HOSPITAL SERVICES

Covered Services for Outpatient Hospital Services are paid in full with no cost to you, except as specifically mentioned below. Benefits for Outpatient Surgery received in a Hospital setting or Freestanding Facility are subject to the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate per visit and then you will be responsible for the Coinsurance amount shown in the **BENEFIT HIGHLIGHTS**, after you have met your program deductible, if applicable.

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SUPPLEMENTAL BENEFITS

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

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

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

1. **Blood and Blood Components.**

2. **Outpatient Private Duty Nursing Service** – Benefits for Outpatient Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care Provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Outpatient Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning; medical equipment uses and monitoring to home caregivers and is not intended to provide long term supportive care. Benefits for Outpatient Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.

3. **Medical and Surgical Dressings, Supplies, Casts and Splints.**

4. **Oxygen and its administration.**

5. **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 calendar year. Naprapathic Services received by an Enrollee prior to the Enrollee's first calendar year do not count towards the maximum Naprapathic Service covered by this Certificate.

6. **Prosthetic Devices** – Benefits will be provided for 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 required for an illness or injury when:

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

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

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

7. **Hearing Implants** - Benefits will be provided for bone anchored Hearing Aids and cochlear implants.

   Note that you may have additional Covered Services as provided in the **OTHER COVERED SERVICES** section of this Certificate.

8. **Orthotic Devices** – That is, a supportive device for the body or a part of the body, head, neck or extremities including, but not limited to leg, back, arm and neck braces, 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 determined by your Primary Care Physician or Woman's Principal Health Care Provider. Benefits for foot orthotics will be limited to a maximum of two devices or one pair of devices per calendar year. Orthotic Devices received by

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an Enrollee prior to the Enrollee's first calendar year do not count towards the maximum Orthotic Devices covered by this Certificate.

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

   Examples of Durable Medical Equipment are compression sleeves to prevent or mitigate lymphedema, wheelchairs, and Complex Rehabilitation Technology (includes Medically Necessary repairs and associated rental of Complex Rehabilitation Technology during those repairs).

   Hospital beds, glucose monitors, cardiopulmonary monitors, lancets and lancing devices and ventilators. Benefits will not be provided for strollers, electric scooters, back-up or duplicate equipment, ramps or other environmental devices, or clothing or special shoes.

10. **Wigs** – This plan provides Benefits for one wig per benefit period (also referred to as a scalp prostheses) for hair loss caused by:

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

YOUR COST FOR COVERED SERVICES

You will be responsible for the Coinsurance amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate for the Covered Services specified above, after you have met your program deductible, if applicable.

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EMERGENCY CARE BENEFITS

This section of your Certificate explains your emergency care benefits.

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

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

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

IN-AREA TREATMENT OF AN EMERGENCY

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

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

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

Payment for In-Area Emergency Treatment

Benefits for emergency treatment received in your Participating IPA's/Participating Medical Group's treatment area will be paid as described in the **BENEFIT HIGHLIGHTS** section of this Certificate.

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate. Thereafter, you will be responsible for paying the Coinsurance amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate, after you have met your program deductible, if any is applicable. However, the emergency room Copayment does not apply to services provided for the treatment of criminal sexual assault. Benefits for the treatment of criminal sexual assault will not be subject to any deductible, Coinsurance with No Cost Share Copayment.

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

OUT-OF-AREA TREATMENT OF AN EMERGENCY

If you are away from your Participating IPA/Participating Medical Group and need to obtain treatment for an Emergency Medical Condition, benefits will be provided for the Hospital and Physician services that you receive. Benefits are available for the initial treatment of the emergency. Benefits are also available for related follow-up care from any Provider (without an order from your Primary Care Physician or Woman's Principal Health Care Provider) if it is not reasonable for you to obtain the follow-up care from your Primary Care Physician or Woman's Principal Health Care Provider. If you are unsure whether or not you are in the Participating IPA's/Participating Medical Group's treatment area, you can call Customer Service at the toll-free telephone number on the back of your Blue Cross and Blue Shield identification card, or they will be identified in the HMO Provider Directory.

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Payment for Out-of-Area Emergency Treatment

Benefits for emergency treatment received outside of your Participating IPA's/ Participating Medical Group's treatment area will be paid as described in the **BENEFIT HIGHLIGHTS** section of this Certificate.

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate. Thereafter, you will be responsible for paying the Coinsurance amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate, after you have met your program deductible, if any is applicable. However, the emergency room Copayment does not apply to services provided for the treatment of criminal sexual assault. Benefits for the treatment of criminal sexual assault will not be subject to any deductible, Coinsurance or Copayment.

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

EMERGENCY AMBULANCE BENEFITS

Benefits for emergency ambulance transportation are available when:

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

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.

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

You will be responsible for the applicable Coinsurance amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate, after you have met your program deductible, if applicable, for emergency ambulance transportation benefits.

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MENTAL HEALTH SUBSTANCE USE DISORDER TREATMENT BENEFITS

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

Covered Services are the same as those provided for any other condition, as specified in the other benefit sections of this Certificate. Benefits for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder include pregnancy and postpartum periods and are available for those who have experienced a miscarriage or stillbirth. In addition, benefits will be provided for these Covered Services for Substance Use Disorder Treatment in a Substance Use Disorder Treatment Facility or a Residential Treatment Center in the Blue Precision Silver HMO 102 - Rx Copays Network. To obtain benefits for Substance Use Disorder treatment, they must be authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

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/or 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.

INPATIENT BENEFITS

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

BENEFIT PAYMENT FOR INPATIENT BENEFITS

Each time you are admitted as an Inpatient to a Hospital, Substance Use Disorder Treatment Facility or Residential Treatment Center, you are responsible for paying the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate, after you have met your program deductible, thereafter, you will be responsible for the Coinsurance amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate.

COST TO YOU FOR OUTPATIENT BENEFITS

Benefits for Outpatient office visits for Substance Use Disorder treatment is subject to the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate per visit and then will be paid at 100% of the Provider Charge.

However, benefits for Outpatient Substance Use Disorder treatment visits to a Specialist Physician's office are subject to the Copayment amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate per visit and then benefits for Covered Services will be paid at 100% of the Provider Charge.

Detoxification

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

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HUMAN ORGAN TRANSPLANT BENEFITS

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

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

Payment for Covered Services received will be the same as that specified in those benefit sections. If there is a change that alters the terms of coverage for prescribed immunosuppressive drugs, the Plan shall notify you or your authorized representative along with your prescribing Physician least 60 days prior to making such change. The notice shall describe the change and include information regarding your prescribing Physician's right to appeal such change.

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

1. If both the donor and recipient have coverage with the Plan, each will have their benefits paid by his or her own program.
2. If you are the recipient and your donor does not have coverage from any other source, the benefits of this Certificate will be provided for both you and your donor. The benefits provided for your donor will be charged against your coverage under this Certificate.
3. If you are the donor and coverage is not available to you from any other source, the benefits of this Certificate will be provided to you. However, benefits will not be provided for the recipient.

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

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

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

1. Organ transplants, and/or services or supplies rendered in connection with an organ transplant, which are Investigational as determined by the appropriate technological body.
2. Drugs which are Experimental/Investigational.
3. Storage fees.
4. Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
5. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
6. Travel time or related expenses incurred by a Provider.
7. Meals.

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HOSPICE CARE BENEFITS

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

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

The following services are covered under the Hospice Care Program:

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

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

1. Durable medical equipment.
2. Home delivered meals.
3. Homemaker services.
4. Traditional medical services provided for the direct care of 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.

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.

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

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OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. Benefits will not be provided for any self-administered drugs dispensed by a Physician. This section of your Certificate explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary. Medical necessity is determined by the Enrollee's Primary Care Physician, Woman's Principal Health Care Provider or treating Provider, as applicable, except as otherwise stated in this Certificate.

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

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

NOTE: The use of an adjective such as Participating, 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:

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

BRAND NAME DRUG (NON-PREFERRED) – Means a Brand Name Drug that is identified on the *Drug List* as a Non-Preferred Brand Name Drug. The *Drug List* is available by accessing the Plan's 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 Plan website at www.bcbsil.com.

COINSURANCE AMOUNT – Means a Copayment that is a percentage amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy 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.

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COPAYMENT AMOUNT – Means the dollar amount or Coinsurance 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 nonprescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self-administration):

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

DRUG LIST – Means a list of all drugs that may be covered under the **OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT** section and related services section of this Certificate. A current list is available on our website 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 the Plan or the entity chosen by the Plan to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with the Plan or the entity chosen by the Plan to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

1. The charge which the particular Pharmacy usually charges for Covered Services, or
2. The agreed upon cost between Participating Pharmacy Provider and the Plan or the entity chosen by the Plan to administer its prescription drug program, whichever is lower.

GENERIC DRUG – Means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs, the Plan 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 Plan's website at www.bcbsil.com. You may also contact Customer Service at the toll-free number indicated on the back of your identification card.

GENERIC DRUG (NON-PREFERRED) – Means a Generic Drug that is identified on the *Drug List* as a Non-Preferred Generic Drug. The *Drug List* is available by accessing the Plan's 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 Plan website at www.bcbsil.com.

HEALTH CARE PRACTITIONER – Means an Advanced Practice Nurse, doctor of medicine, doctor of dentistry, Physician Assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

LEGEND DRUGS – Means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

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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 PRESCRIPTION DRUG PROVIDER or NON-PARTICIPATING PHARMACY PROVIDER – Means the definition set forth in the **DEFINITIONS** section of this Certificate.

PARTICIPATING PRESCRIPTION DRUG PROVIDER or PARTICIPATING PHARMACY – means the definition set forth in the **DEFINITIONS** section of this Certificate.

PHARMACY – Means the definition set forth in the **DEFINITIONS** section of this Certificate.

PREFERRED PARTICIPATING PHARMACY PROVIDER – Means a Participating Pharmacy Provider which has a written agreement with the Plan to provide pharmaceutical services to you or an entity chosen by the Plan to administer its prescription drug program that has been designated as a Preferred Participating Pharmacy Provider.

PREFERRED SPECIALTY PHARMACY PROVIDER – Means a Participating Prescription Drug Provider that has a written agreement with the Plan, or the entity chosen by the Plan to administer its prescription drug program to provide Specialty 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 high-cost oral medications. 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, you should refer to the *Drug List* by accessing the Plan website at www.bcbsil.com or call the customer service toll-free number on your identification card.

SPECIALTY AND COMPLEX CARE DRUG (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 Non-Preferred Specialty and Complex Care Drug. The *Drug List* is available by accessing the Plan's website at www.bcbsil.com.

SPECIALTY AND COMPLEX CARE DRUG (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 Preferred Specialty and Complex Care Drug. The *Drug List* is available by accessing the Plan website at www.bcbsil.com.

ABOUT YOUR BENEFITS

Drug List

Drugs listed on the *Drug List* are selected by the Plan based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Plan. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the *Drug List*. Entire drug classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the *Drug List*.

Positive changes (e.g., 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, drugs moving to a higher payment tier, or drugs requiring prior authorization) occur only annually. However, when there has been a pharmaceutical manufacturer recall or other safety concern, changes to the *Drug List* may occur more frequently.

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

To the extent required by law, and subject to change as described above, all Covered Drugs indicated for the treatment of Substance Use Disorders are subject to the lowest Coinsurance Amount/Copayment Amount for a Generic Drug, Brand Name Drugs or Specialty and Complex Care Drugs, as applicable.

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

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

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

PRIOR AUTHORIZATION REQUIREMENT

When certain medications and drug classes, such as medications used to treat rheumatoid arthritis, growth hormone deficiency, and hepatitis C, are prescribed, you will be required to obtain authorization from the Plan in order to receive 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 have been met. Documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the brand name medication.

The Plan's prescription drug administrator will send a questionnaire to your Physician upon your or your Pharmacy's request. The questionnaire must be returned to the prescription drug administrator who will review the questionnaire and determine whether the reason for the prescription meets the criteria for Medically Necessary care. You and your Physician will be notified of the prescription drug administrator's determination. 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 are 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 website at www.bcbsil.com or call the Customer Service toll-free number on your identification card. Please refer to the *Drug List* provision of this section for more information about changes to these programs.

Blood Glucose Monitors for Treatment of Diabetes

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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.

Controlled Substances Limitation

If it is determined that you may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary and appropriate and coverage restrictions, which may include but not limited to limiting coverage to services provided by a certain Provider and/or Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. For the purpose of this provision, controlled substance medications are medications classified or restricted by state or federal laws. Additional Coinsurance Amount or Copayment Amount and any deductible may apply.

Day Supply

In order to be eligible for coverage under the Policy, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation described in the Policy. Payment for benefits covered under this benefit section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Some drugs covered under your Plan may be subject to certain supply/fill limitations pursuant to diagnoses or new-to-therapy requirements, Plan design, and/or state or federal regulations. For specific drug supply/fill information, please call the customer service toll-free number located on your identification card.

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 on these drugs call the Customer Service toll-free 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 in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if you have not filled one of these medications within 120 days, you may only be able to receive a partial fill (14-15 day supply) of the medication for up to the first 3 months of therapy. This is to help you see how the medication is working for you. If you receive a partial fill, your cost-share may be adjusted to align with the number of pills dispensed. If the medication is working for you and your Physician wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit the https://www.bcbsil.com/prescription-drugs/managing-prescriptions/programs website. Please be advised these lists are subject to change without notice.

Pregnancy Tests:

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

Prescription Refills

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

1. The prescription drugs are covered under this 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 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-filled periods to achieve synchronization; and
6. The prescription drugs do not have special handling or sourcing needs that require a single, designated Pharmacy to fill or refill the Prescription Order.

When necessary to permit synchronization, 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.

Dispensing Limits

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by your Physician, Dentist, Optometrist or Podiatrist, coverage will only be provided for a clinically appropriate predetermined 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 your Physician, Dentist, Optometrist or Podiatrist. To determine if a specific drug is subject to this limitation, you can refer to the *Drug List* by accessing the Plan's website at www.bcbsil.com or call the Customer Service toll-free number on your identification card.

If you require a Prescription Order in excess of the dispensing limit established by the Plan, ask your Physician, Dentist, Optometrist or Podiatrist to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. The Plan has the right to determine dispensing limits, and they may change from time to time. Payment for benefits covered under this benefit section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

COVERED SERVICES

Benefits for Medically Necessary Covered Drugs prescribed to treat you for a chronic, disabling, or life-threatening illness are available if the drug:

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

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2. Has been approved by the FDA for at least one indication and is recognized by substantially accepted peer-reviewed medical literature for treatment of the indication for which the drug is prescribed to treat you for a chronic, disabling or life-threatening illness, except as otherwise provided in the Certificate.

The Coinsurance or Copayment Amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate will apply to each fill of a medication having a unique strength, dosage, or dosage form.

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

Injectable Drugs

Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law including but not limited to epinephrine injectors. Benefits will not be provided under this Benefit Section for any self-administered drugs dispensed by a Physician.

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.

Specialty and Complex Care Drugs

Benefits are available for Specialty and Complex Care Drugs as described under the Specialty and Complex Care Pharmacy Program.

Immunosuppressant Drugs

Benefits are available for immunosuppressant drugs prescribed in connection with a human organ transplant, in addition to branded drugs when written by a prescribing Physician on a prescription as “may not substitute”

Fertility Drugs

Benefits are available for fertility drugs which are self-administered that require a written prescription by federal law.

Contraceptive Drugs

Benefits are available for contraceptive drugs and products shown on the Contraceptive Coverage List that will not be subject to any deductible, Coinsurance Amount with No Cost Share Copayment Amount. You may access the Plan’s website at www.bcbsil.com for more information.

Your share of the cost for all other contraceptive drugs and products will be provided as shown on your Benefit Highlights of this Certificate.

Self-Administered Cancer Medications

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

Cancer Medications

Benefits will be provided for orally administered cancer medications, or self-injected cancer medications that are used to treat certain cancers 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 Secretary of the

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United States Department of Health and Human Services, or its successor agency. Your deductible, Copayment Amount, or Coinsurance Amount will not apply to orally administered cancer medications when received from a Participating Pharmacy Provider. For coverage details on non-self-injected intravenous cancer medications please refer to the **PHYSICIAN BENEFITS** section of this Certificate. Coverage of prescribed orally administered cancer medications will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

Opioid Antagonists

Benefits will be provided for at least one opioid antagonist drug, including the medication product, administration devices and any Pharmacy administration fees related to the dispensing of the opioid antagonist. This includes refills for expired or utilized opioid antagonists.

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

Long-term Antibiotic Therapy

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

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

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

Diabetic Supplies for Treatment of Diabetes

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

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

Abortifacients

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

Hormonal Therapy for Gender Dysphoria

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

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.

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.

Testing, Screening, Vaccinations, and Treatment obtained through Pharmacies

Benefits for select vaccinations are available through certain Participating Pharmacy Providers that have contracted with the Plan to provide this service. To locate one of these contracting Participating Pharmacy Providers in your area, call the customer service toll-free number on your identification card. At the time you receive services, present your identification card to the pharmacist. This will identify you as a participant in the Plan's health care Plan provided by your employer. The pharmacist will inform you of the amount for which you are responsible for, if any.

Each Participating Pharmacy Provider that has contracted with the Plan to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject

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to state regulations are not available under this benefit section. Refer to your Plan's medical coverage for benefits available for childhood immunizations.

90-Day Supply Prescription Drug Program

The 90-Day Supply Prescription Drug Program provides delivery of Covered Drugs directly to your home address. In addition to the benefits described in this benefit section, your coverage includes benefits for Maintenance Drugs and diabetic supplies obtained through the 90-Day Supply Prescription Drug Program. For information about this program, call the customer service toll-free number on your identification card or access the Plan's website at www.bcbsil.com.

Some drugs may not be available through the 90-Day Supply Prescription Drug Program. If you have any questions about the 90-Day Supply Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the mail order form, you may access the Plan's 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 credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

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.

Specialty and Complex Care Pharmacy Program

This Specialty and Complex Care Pharmacy 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 and Complex Care Pharmacy Provider. When you obtain Specialty and Complex Care Drugs from 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) dispensed.

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.

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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. In the event MedsYourWay fails to provide, or continue to provide, the benefit as stated, there will be no impact to You. In such an event, you will pay the Plan's pharmacy benefit copay.

MedsYourWay may not be available in all states or pharmacies and will be operated only to the extent permitted by law.

YOUR COST FOR PRESCRIPTION DRUGS

How Member Cost 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) Specialty and Complex Care Drugs and may contain some Generic Drugs.
- Tier 4 – includes mostly Brand Name Drugs (Non-Preferred) Specialty and Complex Care Drugs 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.

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

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. To verify your payment amount for a drug, visit the Plan's website at www.bcbsil.com and log in to Blue Access for Members SM or call the number on the back of your identification card. Benefits will be provided as shown on the Benefit Highlights of this Certificate.

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If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on your behalf, that amount will be applied to your program deductible or out-of-pocket expense limit.

30-Day Supply Prescription Drug Program

Benefit payment for the 30-day supply prescription drug program

The benefits you receive and the amount you pay will differ depending upon the type of drugs, or diabetic supplies or insulin and insulin syringes obtained and whether they are obtained from a Participating Pharmacy.

When you purchase drugs or diabetic supplies from a Participating Prescription Drug Provider, you will not be charged any amount other than the specified amounts shown in the **BENEFIT HIGHLIGHTS** section of this Certificate. You will be charged the appropriate amount for each prescription.

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

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

For certain maintenance type drugs, larger quantities may be obtained through the 90-day supply prescription drug program. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives.

For additional information on these drugs, contact the customer service toll-free number on your identification card.

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

90 Day Supply Prescription Drug Program

Benefit payment for the 90-day supply prescription drug program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs and diabetic supplies which may be purchased through a retail or mail order Pharmacy participating in the 90-day supply prescription drug program. You will not be charged any amount other than the appropriate Copayment amount specified in the **BENEFIT HIGHLIGHTS** section of this Certificate.

You may also receive coverage for up to a 12-month supply for dispensed contraceptives.

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

Should you choose to obtain a 90-day supply Prescription Order from a mail order Pharmacy, you may access the Plan's website at www.bcbsil.com or call the customer service toll-free number on your identification card.

EXCLUSIONS

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

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

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2. Non-FDA approved Drugs.

3. 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 drugs or covered devices for which no valid Prescription Order is obtained).

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

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

6. Administration or injection of any drugs.

7. Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).

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

9. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether benefits are, or could upon proper Claim be, provided under the Workers' Compensation law.

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

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

12. Drugs 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 of beyond the time period allowed by law.

13. 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.

14. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Certificate.

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

15. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.

16. Drugs, that the use or intended use of which would be illegal, abusive, not Medically Necessary, or otherwise improper.

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

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18. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care Plan, or for which benefits have been exhausted.
19. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
20. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
21. 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.
22. Athletic performance enhancement drugs.
23. Drugs to treat sexual dysfunction
24. Allergy serum and allergy testing materials.
25. Some drugs manufactured under multiple names and that have many therapeutic equivalents. The Plan may limit benefits to specific therapeutic equivalents.
26. Compound drugs.
27. Institutional packs and drugs which are repackaged by anyone other than the original manufacturer.
28. Drugs determined to have inferior efficacy or significant safety issues.
29. Bulk Powders.
30. Diagnostic agents (except for diabetic testing supplies or test strips).
31. Medications in depot or long-acting formulations that are intended for use longer than the covered days' supply amount.
32. Certain drug classes where there are over-the-counter alternatives available.
33. Benefits will not be provided for any self-administered drugs under this benefit section dispensed by a Physician.
34. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield of Illinois may limit benefits to only certain therapeutic equivalents/therapeutic alternatives.
35. 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.
36. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
37. Drugs required by law to be labeled: "Caution – Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs, or are Experimental/Investigational, except as specifically mentioned in this Certificate.

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PEDIATRIC VISION CARE BENEFITS

Your coverage includes benefits for pediatric vision care. This section of your Certificate explains what those benefits are.

DEFINITIONS

In addition to the definitions found in the **DEFINITIONS** section of this Certificate, the following definitions are applicable to your vision care benefits:

Benefit Period – For purposes of this **PEDIATRIC VISION CARE BENEFITS** section, a period of time that begins on the later of the following:

1. The member's effective date of coverage under this Certificate, or
2. The last date a vision examination was performed on the member or that Vision Materials were provided to the member, whichever is applicable, and continues for the next 12 months. Later Benefit Periods will begin on the first day that you receive a Covered Service after expiration of your prior Benefit Period. (A Benefit Period does not coincide with a calendar year and may differ for each covered member of a family).

Contact Lenses – Means ophthalmic corrective lenses, either glass or plastic, ground or molded to be fitted directly on your eye.

Low Vision – Means a significant loss of vision but not total blindness.

Ophthalmologist – Means a duly licensed ophthalmologist.

Optician – Means a duly licensed optician.

Optometrist – Means a duly licensed optometrist.

Vision Care Provider – Means any individual, partnership, proprietorship or organization lawfully and regularly engaged in the business of prescribing and/or dispensing corrective lenses prescribed by a Physician, a licensed Ophthalmologist or Optometrist operating within the scope of their license, or a dispensing Optician.

Participating Vision Care Provider – Is a Vision Care Provider which has a written agreement with Blue Cross and Blue Shield of Illinois.

Non-Participating Vision Care Provider – Is a Vision Care Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois.

Vision Materials – Corrective Lenses and/or Frames.

ELIGIBILITY

Children who are covered under this Certificate, up to age 19, are eligible for coverage under this benefit section.

NOTE: Once coverage is lost under this Certificate, all benefits cease under this benefit section. Extension of benefits due to disability, state or federal continuation coverage and conversion option privileges are not available under this benefit section.

COVERED SERVICES

Your vision care coverage provides benefits for:

1. Lenses.
2. Frames.
3. Contact Lenses.

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4. Low Vision devices; and

5. Laser Vision Correction Surgery (Lasik) – You are entitled to receive a discount for traditional and custom Lasik from participating Physicians and affiliated laser centers. You may call the customer service number on the back of your identification card for information on participating Physicians and affiliated laser centers.

You are entitled to receive one of the Covered Services above each Benefit Period. In addition, benefits will be provided for one vision examination each Benefit Period. However, additional benefits will be provided within the Benefit Period if a prescription change is required from previous Lenses covered under this benefit section. No additional benefits will be provided for tinted, photo-sensitive or anti-reflective Lenses above the benefit allowance for regular Lenses.

Benefits will be provided for one pair of Lenses and a Frame and/or one pair of Contact Lenses each Benefit Period. Benefits will be provided for additional Lenses during a Benefit Period (but still subject to one total Benefit Period payment maximum) if required because the prescription for the Lenses has changed.

Benefits will also be provided for one comprehensive Low Vision evaluation every 5 years. Your benefits for Low Vision also include such devices as high-powered spectacles, magnifiers, telescopes and for follow-up care. Follow-up care is limited to four visits every 5 years.

To be eligible for benefits, Lenses, Frames and Contact Lenses must be provided by a Participating Vision Care Provider. Benefits are not available for Lenses, Frames or Contact Lenses received from a non-participating Vision Care Provider.

Benefits are available for Covered Services rendered by a Physician, Optometrist or Optician.

If your coverage under this Certificate should terminate, benefits will be provided for Lenses, Frames or Contact Lenses that were ordered prior to your termination date if you receive them within 30 days of your termination date.

HOW THIS VISION CARE PLAN WORKS

Under the vision care Plan, you may visit any covered Provider and receive benefits for a vision examination. In order to maximize benefits for most covered Vision Materials, however, you must purchase them from a Participating Vision Care Provider.

Before you go to a Participating Vision Care 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 identification card, be sure to say that you are a member of the Blue Cross and Blue Shield of Illinois vision care Plan so that your eligibility can be verified.

To locate a Participating Vision Care Provider, visit the EyeMed Vision Care, LLC (EyeMed) 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 Care 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 to 7:00 P.M. (Central Time) at 1-844-684-2254. An Interactive Voice Response Unit is also available outside normal business operating hours. (Please direct member enrollment, termination and other subscriber or Dependent eligibility questions to the Plan, not to EyeMed). Members using a TTY (Teletypewriter) because of 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.

You may receive your eye examination and eyeglasses/Contact Lenses 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 Provider and there may be additional professional charges if you seek Contact Lenses from a Provider other than one who performed your eye examination.

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Fees charged for services other than a covered vision examination or covered Vision Materials and amounts in excess of those payable under this benefit section, must be paid in full by you to the Provider, whether or not the Provider is a Participating Vision Care Provider. Benefits under this benefit section cannot be combined with any discount, promotional offering, or other health benefit Plans. Allowances are one time use benefits; no remaining balances are carried over to be used later.

Benefits for pediatric vision care services will be subject to the Copayments as described in the Pediatric Vision Care Schedule in the **BENEFIT HIGHLIGHTS** section of this Certificate.

LIMITATIONS AND EXCLUSIONS

In addition to the **EXCLUSIONS — WHAT IS NOT COVERED** section of this Certificate, this benefit section does not cover services or supplies 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.
5. Non-prescription sunglasses (except for discount).
6. Services rendered after the date an insured person ceases to be covered under the Certificate, except when Vision Materials ordered before coverage ended are delivered and the services rendered to the insured person are within 31 days of 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 Vision Care Covered Service on the **BENEFIT HIGHLIGHTS.**
10. Services and materials that are Experimental/Investigational.
11. Services or materials which are prior to your effective date.
12. Services and materials incurred after the termination date of your coverage, unless otherwise indicated.
13. Services and materials not meeting accepted standards of optometric practice.
14. Services and materials resulting from your failure to comply with professionally prescribed treatment.
15. Telephone consultations.
16. Any charges for failure to keep a scheduled appointment.
17. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
18. Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in illegal occupation, or participating in a riot, rebellion or insurrection.
19. Office infection control charges.

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20. Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts.
21. State or territorial taxes on vision services performed.
22. Medical treatment of eye disease or injury.
23. Visual therapy.
24. Special lens designs or coatings other than those described in this benefit section.
25. Replacement of lost or stolen eyewear.
26. Two pairs of eyeglasses in lieu of bifocals.
27. Services not performed by licensed personnel.
28. Prosthetic devices and services.
29. Insurance of Contact Lenses.
30. Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

PEDIATRIC DENTAL CARE BENEFITS

COVERED SERVICES

The benefits of this section are subject to all the terms and conditions of this Certificate. All Covered Services listed in this section are subject to the **EXCLUSIONS-WHAT IS NOT COVERED** section of this Certificate, which lists services, supplies, situations or related expenses that are not covered.

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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, or other Provider operating within the scope of their license. When the term “Dentist” is used in this Certificate, it will mean Physician or Dentist.

ELIGIBILITY

Children who are covered under this Certificate, up to age 19, are eligible for coverage under this benefit section. For purposes of this benefit section only, the following definition shall apply:

MAXIMUM ALLOWANCE – Means the amount determined by the Plan, which Participating Dentists have agreed to accept as payment in full for a particular dental Covered Service. All benefit payments for Covered Services rendered by Dentists will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by the Plan.

COVERED SERVICES

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 caregivers.
6. Oral Examinations – The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every calendar year 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 re-evaluations.

Preventive Dental 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 Persons under age 19 and are limited to two applications every 12 months. Your program deductible will not apply for topical fluoride application benefits.

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 Periodontal Services") every 12 months.

Diagnostic Radiographs

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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.

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

Miscellaneous Preventive Dental 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 Eligible Person's under age 19.
2. Space Maintainers – Benefits for space maintainers are limited to a lifetime maximum of one appliance per missing tooth site for your Dependent child(ren) up to age 19.
3. 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:

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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.
4. Therapeutic parenteral drug injections will be covered.

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. These services are considered part of the root canal procedure if root canal therapy is performed within 45 days of service.
2. Root canal therapy, including treatment Plan, clinical procedures, working and post-operative radiographs and follow-up care.
3. Apexification/recalcification procedures and apicoectomy/periradicular services including Surgery, retrograde filling, root amputations and hemisection.

Benefits will not be provided for the following Endodontic Services.

1. Endodontic treatments provided within 12 months of the initial endodontic therapy by the same Dentist.
2. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, 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 vestibuloplasty.
3. Excision of benign odontogenic tumor/cysts.
4. Excision of bone tissue.
5. Incision and drainage of an intraoral abscess.
6. Other Medically Necessary surgical and repair procedures not specifically excluded in this Certificate.

Intraoral soft tissue and drainage are 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 congenital malformation.
2. Prophylactic removal of third molars or impacted teeth (asymptomatic, non-pathological), or for complete bony impactions covered by another benefit Plan.

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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 includes:

1. Gingivectomy or gingivoplasty and gingival flap procedures (including root planning)—Benefits are limited to one per 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 per quadrant. Benefits are not available for bone grafts in conjunction with extraction, apicoectomy or any non-Covered Service or non-covered implants.

5. Soft tissue grafts/allografts (including donor site)—Benefits are limited to one per site every 24 months, except for pedicle soft tissue grafts.

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 of 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:

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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 every 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. Benefits will be limited to once every 60 months.
4. Maxillofacial Prosthetics.

NOTE: 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 only if it is determined to be Medically Necessary. Claim reviews 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. Treatment to replace teeth which are missing prior to the Coverage Date.

Benefits will not be provided for the following Prosthodontic Services:

1. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
2. Treatment to replace teeth which are missing prior to Coverage Date.
3. Congenitally missing teeth.

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. Recommendation of inlays/onlays, crowns, bridges, and post and core—Benefits will be limited to two recommendations every 12 months. However, any recommendation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.
3. Core build up, 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 services 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.

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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 or dentofacial malformation 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. Covered services include:

1. Diagnostic orthodontic records and radiographs.
2. Limited, interceptive and comprehensive orthodontic treatment.
3. Orthodontic retention.

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. 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.
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, you are responsible for the remaining balance of treatment costs.
7. Recommendation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for your ongoing care is not covered.
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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YOUR COST FOR PEDIATRIC DENTAL CARE SERVICES

You will be responsible for the Coinsurance amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate for the Covered Services described in this benefit section.

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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 dental 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's 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 cancels 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 or 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 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.

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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. 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 Services subsection of the **PEDIATRIC DENTAL CARE BENEFITS** 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 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 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 member.

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.

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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 teeth, 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 the 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 Coverage Date.

27. Charges for occlusion analysis, diagnostic casts or occlusal adjustments.

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 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 anesthesia or other drugs or medicaments and/or their application.

39. Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist on the same tooth.

40. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of performed dowel and post, or post removal.

41. Endodontic therapy if you discontinue endodontic treatment.

42. Surgical services related to congenital malformation.

43. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit Plan.

44. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

45. 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.

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46. Guided tissue regeneration, or for biologic materials to aid tissue regeneration.

47. 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.

48. 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, altering vertical dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.

49. The restoration of occlusion on incisal edges due to bruxism or harmful habits.

50. Treatment to replace teeth which were missing prior to the Coverage Date.

51. Congenitally missing teeth.

52. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

53. Replacement or repair of an orthodontic appliance.

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 Plan. You must provide the Plan with all documents it needs to enforce its rights under this provision.

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PRE-ADMISSION CERTIFICATION AND CONCURRENT REVIEW

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

PRE-ADMISSION CERTIFICATION

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

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

CONCURRENT REVIEW

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

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

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EXCLUSIONS – WHAT IS NOT COVERED

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

1. Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the **EMERGENCY CARE BENEFITS** section, **HOSPITAL BENEFITS** section, **PEDIATRIC VISION CARE BENEFITS** section, **PEDIATRIC DENTAL CARE BENEFITS** section and, for routine vision examinations in the **PHYSICIAN BENEFITS** section of this Certificate.
2. Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated, unless otherwise stated in this Certificate.
3. Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a “small business” under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
4. Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government whether or not those payments or benefits are received except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
5. Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.
6. Services or supplies that do not meet accepted standards of medical or dental practice including, but are not limited to, services which are Experimental/Investigational in nature. This exclusion however does not apply to a) the cost of routine patient care associated with Experimental/Investigational treatment if you are a qualified individual participating in an Approved Clinical Trial, if those services or supplies would otherwise be covered under this Certificate if not provided in connection with an Approved Clinical Trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).You may contact customer service at the toll-free telephone number on the back of your identification Card for more information about what Experimental/Investigational Services or Supplies may be excluded.
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 Services.
10. Respite Care Services, except as specifically mentioned under Hospice Care Benefits.
11. Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. However, this exclusion does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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12. Special education therapy such as music therapy or recreational therapy, except as specifically provided for in this Certificate.
13. Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease.
14. Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
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 similar coverage.
16. Charges for failure to keep a scheduled visit or charges for completion of a Claim form or charges for the transfer of medical records.
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, splints, specialized equipment, appliances, ambulatory apparatus or battery implants except as specifically stated in this Certificate.
19. Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient or unrelated to the treatment of a disease or injury.
20. Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements, except as stated in this Certificate.
21. Blood derivatives which are not classified as drugs in the official formularies.
22. Hypnotism.
23. Inpatient Private Duty Nursing Service.
24. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate.
25. Maintenance Care.
26. Self-management training, education and medical nutrition therapy, except as specifically stated in this Certificate.
27. Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.
28. Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in this Certificate.
29. Repair or replacement of appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.
30. Services or supplies rendered for human organ or tissue transplants except as specifically provided for in this Certificate.
31. Wigs (also referred to as scalp prostheses), unless otherwise specified in this Certificate.
32. Services or supplies rendered for Infertility treatment except as specifically provided for in this Certificate.
33. Eyeglasses, contact lenses, which are not Medically Necessary, except as specifically provided for this Certificate.

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34. Acupuncture.

35. Reversal of vasectomies.

36. Services and supplies rendered or provided outside of the United States, if the purpose of the travel to the location was for receiving medical services, supplies or drugs.

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

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

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

40. If a service is not covered, the Plan will not cover any services related to it, except for routine patient care for participants in an Approved Clinical Trial. Related services are:

    a. Services in preparation for the non-Covered Service.

    b. Services in connection with providing the non-Covered Service.

    c. Hospitalization required to perform the non-Covered Service.

    d. Services that are usually provided following the non-Covered Service, such as follow-up care or therapy after Surgery.

41. 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.

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

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COORDINATION OF BENEFITS

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

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

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but
2. May be reduced when, under the order of benefits determination rules, another Benefit Program determines its benefits first. This reduction is described below in "When this Benefit Program is a Secondary Program."

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

ALLOWABLE EXPENSE – Means a Covered Service, when the Covered Service is covered at least in part by one or more Benefit Program covering the person for whom the Claim is made.

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

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

BENEFIT PROGRAM – Means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

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

Each contract or other arrangement under (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

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

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

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

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 other than a Dependent, for example a retired employee.

2. Dependent child if Parents not Separated or Divorced

   Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a Dependent of different persons, (i.e., “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 parents 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 the Plan and, upon its request, to provide a copy of the court decree.

4. Dependent Child if Parents Share Joint Custody

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

5. Young Adults as a Dependent

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

6. Active or Inactive Employee

   The benefits of neither a Benefit Program that covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Benefit Program that covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of benefits, this rule shall not apply.

7. Continuation Coverage

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

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

   b. Second, the benefits under the continuation coverage.

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

8. Length of Coverage

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

The benefits of this Benefit Program will be reduced when:

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

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

When the benefits of this Benefit Program are reduced as described, 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

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

The foregoing notwithstanding, you will only be responsible for any applicable Copayments, deductibles or Coinsurance as described in this Certificate.

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

PLEASE NOTE, YOU MAY BE ENTITLED TO RECEIVE ADDITIONAL BENEFITS

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

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

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HOW TO FILE A CLAIM

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

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

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

1. An itemized bill from the Hospital, Physician or other Provider (including the Provider's name and address, the patient's name, the diagnosis (including appropriate codes), the date of service, a description of the service (including appropriate codes) and the Claim Charge).
2. The Eligible Person's name and Plan ID number.
3. The patient's name, age and sex.
4. Any additional relevant information.

Mail all of that information to:

Blue Cross and Blue Shield of Illinois
300 East Randolph Street
Chicago, Illinois 60601-5099

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

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

FILING OUTPATIENT PRESCRIPTION DRUG PROGRAM CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits under the Outpatient Prescription Drug Program. This is primarily true when you did not receive an identification card, the Pharmacy was unable to transmit a Claim or you received benefits from a non-participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete an Outpatient Prescription Drug Program Claim Form. These forms are available from your Employee Benefits Department or from the Plan.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

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

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

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

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Plan will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that the Plan does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Plan will usually notify you, your valid assignee, or your authorized representative when all information required to process a Claim in accordance with the terms of the benefit program within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see “Payment of Claims and Assignment of Benefits” provisions in the **OTHER THINGS YOU SHOULD KNOW** section of this Certificate.)

If a Claim Is Denied or Not Paid in Full

If the Claim for benefit is denied, you or your authorized representative shall be notified in writing of the following:

1. The reasons for determination.
2. A reference to the benefit Plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination.
3. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary.
4. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.
5. An explanation of the Plan's internal review/appeals and external review processes (and how to initiate a review/appeal or external review). Specifically, this explanation will include:
    a. An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);
    b. An explanation that you may ask for an external review with an Independent Review Organization (“IRO”) not associated with the Plan if your appeal was denied based on any of the reasons below. You may also ask for external review if the Plan failed to give you a timely decision (see d. below), and your Claim was denied for one of these reasons:
        i. A decision about the medical need for or the experimental status of a recommended treatment.
        ii. Your health care coverage was rescinded. For additional information, see the definition of Rescission in the **DEFINITIONS SECTION** of this Certificate.

        To ask for an external review, complete the Request for External Review form that will be provided to you and available at *https://*insurance.illinois.gov/*ExternalReview/ExternalReviewMain.htlm* 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:

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i. Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health or ability to regain maximum function.

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

iii. The request for treatment is Experimental or Investigational and your health care Provider states in writing that the treatment would be much less effective if not promptly started.

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

e. Decisions on standard appeals are considered timely if the Plan sends you a written decision for appeals that need medical review within 15 business days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. Decisions on expedited appeals are considered timely if the Plan sends you a written decision within 48 hours of your request for an expedited appeal.

6. In certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s).

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

8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits.

9. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request.

10. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request.

11. In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such Claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification; and

12. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For Complaints and general Inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(866) 445-5364 Toll-free phone
(217) 558-2083 Fax number
DOI.complaints@illinois.gov Email address
https://mc.insurance.illinois.gov/message-center.nsf

For external review requests:

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Illinois Department of Insurance
Office of Consumer Health Insurance External Review Unit
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address
https://mc.insurance.illinois.gov/message-center.nsf

Chicago Office
115 S. LaSalle Avenue, 13th floor
Chicago, IL 60603
(312) 814-2420

INQUIRIES AND COMPLAINTS

An “Inquiry” is a general request for information regarding Claims, benefits, or membership.

A “Complaint” is an expression of dissatisfaction by you either orally or in writing.

The Plan has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

1. Claims
2. Quality of care

When your Complaint relates to dissatisfaction with a Claim denial (or partial denial), then you have the right to a Claim review/appeal as described in the **CLAIM APPEAL PROCEDURES**.

To pursue an Inquiry or a Complaint, you may contact customer service at the number on the back of your identification card, or you may write to:

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

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

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

1. **Urgent Care Clinical Claim** – is any pre-service Claim for benefits for Medical Care or treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the

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claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

2. **Pre-Service Claim** – is any non-urgent request for benefits or a determination with respect to which the terms of the benefit Plan condition receipt of the benefit on approval of the benefit in advance of obtaining Medical Care.

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

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Plan must notify you within:	24 hours**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Plan within:	48 hours after receiving notice
The Plan must notify you of the Claim determination (whether adverse or not):	
If the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	48 hours
After receiving the completed Claim (if the initial Claim is incomplete), within:	48 hours

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

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

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, the Plan must notify you within:	5 days*
If your Claim is incomplete, the Plan must notify you within:	15 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Plan within:	45 days after receiving notice
The Plan must notify you of the Claim determination (whether 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

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

** This period may be extended one time by the Plan for up to 15 days, provided that the Plan both

1. Determines that such an extension is necessary due to matters beyond the control of the Plan and

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2. Notifies you, prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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Post-Service Claims

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

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

Concurrent Care

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

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

CLAIM APPEAL PROCEDURES

Claim Appeal Procedures - Definitions

Adverse Benefit Determination - Means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide in response to a Claim, Pre-Service Claim or Urgent Care Clinical Claim or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. If an Ongoing Course of Treatment had been approved by the Plan and the Plan reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. Rescission of coverage is also an Adverse Benefit Determination. Rescission does not include a termination of coverage for reasons related to non-payment of premium.

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

Adverse Determination means:

1. A determination by the Plan or its designated utilization review organization that, based upon the information provided, a request for a benefit under the Plan's health benefit Plan upon application of any utilization review technique does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or it is determined to be Experimental or Investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;
2. The denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by the Plan or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or

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3. A Rescission of coverage determination. For additional information, see 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 continued hospitalization. Before authorization of benefits for an Ongoing Course Of Treatment is terminated or reduced, the Plan will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the Ongoing Course Of Treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent Clinical Appeal, the Plan will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Plan will render a decision on the appeal within 24 hours after it receives the requested information, but in no event more than 48 hours after the appeal has been received by the Plan.

How to Appeal an Adverse Benefit Determination

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

An appeal of an Adverse Benefit Determination may be filed by you, or a person authorized to act on your behalf. In some circumstances, a health care Provider may appeal on 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 the Plan at the number on the back of your identification card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

If you believe the Plan incorrectly denied all or part of your benefits, you may have your Claim reviewed. The Plan will review its decision in accordance with the following procedure:

1. Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Plan to request a Claim review. The Plan will need to know the reasons why you do not agree with the Adverse Benefit Determination.
2. In support of your Claim review, you have the option of presenting evidence and testimony to the Plan. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.
3. To contact the Plan to request a Claim review or appeal an Adverse Benefit Determination, use the following contact information:

Blue Cross and Blue Shield of Illinois
Claim Review Section
P.O. Box 660603
Dallas, TX 75266-0603
1-800-538-8833 Toll-free number
1-866-414-4258 Fax number
1-918-551-2011 Fax number for Urgent requests
send a secure email by using our message center by logging into

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During the course of your internal appeal(s), the Plan will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by the Plan in connection with the appealed Claim, as well as any new or additional rationale for a denial at the internal appeals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. The Plan may extend the time period described in this Certificate for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Plan and/or by external advisors, but who were not involved in making the initial denial of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Plan.

Timing of Non-Urgent Appeal Determinations

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

The Plan will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 15 business days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 15 business days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service.

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

Notice of Appeal Determination

The Plan will notify the party filing the appeal, you, and, if a Clinical Appeal, any health care Provider who recommended the services involved in the appeal.

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

1. The reasons for the determination.
2. A reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination.
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.
4. An explanation of the Plan's internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal and external appeal. Specifically, this explanation will include:
    a. An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add).

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b. An explanation that you may ask for an external review with an Independent Review Organization ("IRO") not associated with the Plan if your appeal was denied based on any of the reasons below. You may also ask for external review if the Plan failed to give you a timely decision (see d. below), and your Claim was denied for one of these reasons:

i. A decision about the medical need for or the Experimental status of a recommended treatment.

ii. Your health care coverage was rescinded. For additional information, see the definition of Rescission in the **DEFINITIONS** section of this Certificate.

To ask for an external review, complete the Request for External Review form that will be provided to you and available at *https://insurance.illinois.gov/ExternalReviewReviewMain.html* 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. The Plan failed to give you a decision within 48 hours of your request for an expedited appeal; or

iii. The request for treatment is Experimental or Investigational and your health care Provider states in writing that the treatment would be much less effective if not promptly started; or

iv. The Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which you received Emergency Services, but have not been discharged from a facility.

d. Decisions on standard appeals are considered timely if the Plan sends you a written decision for appeals that need medical review within 15 business days after we receive any needed information, but not later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. Decisions on expedited appeals are considered timely if the Plan sends you a written decision within 48 hours of your request for an expedited appeal.

5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative.

6. In certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);

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

8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits.

9. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, 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.

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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 to file an external review regardless of the status of a Provider appeal.

15. The number of levels of appeal available (no more than two levels for groups and one level for individuals) under the Plan and the level of appeal applicable to the adverse determination within the notice.

16. A Request for External Review Form, Authorized Representative Form, (HCP) Health Care Provider Certification Request for Expedited Review Form, and (HCP) Health Care Provider Certification Experimental/Investigational Review Form; and

17. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

    For Complaints and general Inquiries:

    Illinois Department of Insurance
    Office of Consumer Health Insurance
    320 West Washington Street
    Springfield, Illinois 62767
    (866) 445-5364 Toll-free phone
    (217) 558-2083 Fax number
    DOI.complaints@illinois.gov Email address
    https://mc.insurance.illinois.gov/message-center.nsf

    For external review requests:

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

    Chicago Office
    115 S. LaSalle Avenue, 13th floor
    Chicago, IL 60603
    (312) 814-2420

If the Plan's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your Claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **INDEPENDENT EXTERNAL REVIEW** section below.

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You may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Plan of the Complaint. The Plan will have 21 days to respond to the Illinois Department of Insurance.

The operations of the Plan are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

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

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(866) 445-5364Toll-free phone
(217) 558-2083 Fax number
DOI.complaints@illinois.gov Email address
https://mc.insurance.illinois.gov/message-center.nsf

Chicago Office
115 S. LaSalle Avenue, 13th floor
Chicago, IL 60603
(312) 814-2420

You must exercise the right to internal appeal as a precondition to take any action against the Plan, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

Forum Selection

In the event of any dispute relating to or arising from this Plan, the jurisdiction and venue for the dispute is the United States District Court for the Northern District of Illinois. If, and only if, the United States District Court for the Northern District of Illinois lacks subject-matter jurisdiction over such dispute, the jurisdiction and venue for the dispute is the Circuit Court of Cook County, Illinois.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Plan Headquarters at 1-800-538-8833. The Plan's offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday. Customer service hours and operations are subject to change without notice.

Blue Cross and Blue Shield of Illinois
P.O. Box 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).

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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).

Final Adverse Determination means an Adverse Determination involving a Covered Service that has been upheld by the Plan or its designated utilization re-view organization, at the completion of the Plan's internal grievance process procedures.

1. **Standard External Review**

   You or your authorized representative must submit a written request for a standard external independent review to the Illinois Department of Insurance ("IDOI") within 4 months of receiving an Adverse Determination or Final Adverse Determination. Your request should be submitted to the IDOI at the following address:

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

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

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

   a. You where an Enrollee 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 benefit program, but the Plan has determined that the health care service is not covered.

   c. You have exhausted the Plan's internal appeal process, unless you are not required to exhaust the Plan's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and

   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, the Plan will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for the Plan's determination that the service or treatment is Experimental or Investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, your health care Provider has certified that one of the following situations is applicable:

   a. Standard health care services or treatments have not been effective in improving your condition.

   b. Standard health care services or treatments are not Medically appropriate for you.

   c. There is no available standard health care services or treatment covered by the Plan that is more beneficial than the recommended or requested service or treatment.

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d. In addition, 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

e. 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, the Plan shall notify the IDOI, you and your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the IDOI, you and your authorized representative shall be notified by the Plan in writing of what materials are required to make the request complete or the reason for its ineligibility. The Plan's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the IDOI's decision shall be in accordance with the terms of your benefit program (unless such terms are inconsistent with applicable laws) and shall be subject to all applicable laws.

4. **Assignment of IRO.** When the IDOI receives notice that your request is eligible for external review following the preliminary review, the IDOI will, within one business day after the receipt of the notice, a) assign an IRO on a random basis from those IROs approved by the IDOI; and (b) notify the Plan, you and your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

   Within five business days after the date of receipt of the notice provided by the IDOI of assignment of an IRO, the Plan shall provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may, within five business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after five business days. If the Plan or its designated utilization review organization does not provide the documents and information within five business days, the IRO may end the review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by the Plan or designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the external review. Within one business day after making the decision to end the external review, the IRO shall notify the Plan, you and, if applicable, your authorized representative, of its decision to reverse the determination.

   If you or your authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to the Plan within one business day of receipt from you or your authorized representative. Upon receipt of such information, the Plan may reconsider the Adverse Determination or Final Adverse Determination. Such reconsideration shall not delay the external review. The Plan may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the external review, the Plan shall notify the IDOI, the IRO, you, and if applicable, your authorized representative of its decision to reverse the determination.

5. **IRO's Decision.** In addition to the documents and information provided by the Plan and you, or if applicable, your authorized representative, the IRO shall also consider the following information if available and appropriate:

   a. Your pertinent medical records.

   b. Your health care Provider's recommendation.

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c. Consulting reports from appropriate health care Providers and other documents submitted to the Plan or its designated utilization review organization, you, your authorized representative or your treating Provider.

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 the Plan or its designated utilization review organization; and

g. The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

Within one business day after the receipt of notice of assignment to conduct an external review with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is Experimental or Investigational, the IRO will select one or more clinical reviewers, as it determines is appropriate, to conduct the external review, which clinical reviewers must meet the minimum qualifications set forth in the Illinois Health Carrier External Review Act, and neither you, your authorized representative, if applicable, nor the Plan will choose or control the choice of the Physicians or other health care professionals to be selected to conduct the external review. Each clinical reviewer will provide a written opinion to the IRO within 20 days after being selected by the IRO to conduct an external review on whether the recommended or requested health care service or treatment should be covered.

The IRO will make a decision within 20 days after the date it receives the opinion of each clinical reviewer, which will be determined by the recommendation of a majority of the clinical reviewers.

Within five days after the date of receipt of the necessary information, but in no event more than 45 days after the date of receipt of request for an external review, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the IDOI, the Plan, you and your authorized representative, if applicable, of its decision.

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

The written notice will include:

a. A general description of the reason for the request for external review.

b. The date the IRO received the assignment from the IDOI.

c. The time period during which the external review was conducted.

d. References to the evidence or documentation including the evidence-based standards, considered in reaching its decision or, in the case of external reviews of Experimental or Investigational services or treatments, the written opinion of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation.

e. The date of its decisions.

f. The principal reason or reasons for its decision, including what applicable, if any, evidence–based standards that were a basis for its decision; and

g. The rationale for its decision.

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Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review.

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

Standard External Review

Standard External Review	Timing
If you receive an Adverse Determination or a Final Adverse Determination, you may file a request for an external review within:	4 months after receipt of notice
The Plan shall complete a preliminary review of the request within:	5 business days after receiving request
The Plan must notify you whether the request is complete and eligible for external review:	
If the request is not complete the Plan shall notify you and include what information or materials are required within:	one business day after the preliminary review
If the request is not eligible for external review the Plan shall notify you and include the reasons for its ineligibility within:	one business day after the preliminary review
The Plan shall notify the IDOI, you or your authorized representative that a request is eligible for external review within:	one business day after the preliminary review
The IDOI shall assign an independent review organization (IRO) within:	one business day after receipt of the notice
The Plan shall provide to the assigned IRO the documents and any information used in making the Adverse Determination or Final Adverse Determination within:	5 business days of notice of assigned IRO
The IRO shall provide notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination within:	5 days after receipt of all required information from you (but no more than 45 days after the receipt of request for external review)

6. **Expedited External Review**

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination; (b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with the Plan. In addition, if a Final Adverse Determination concerns 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

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representative may file the request immediately after receipt of notice of a Final Adverse Determination if the Plan fails to provide a decision on a request for an expedited internal appeal within 48 hours.

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 BCBSIL Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision, and your right to request an external review, will be provided to you, your authorized representative, if any, your Physician, and/or the Hospital or other Provider, within 24 hours, and will specify the dates that are not in Benefit. For further details regarding Medically Necessary care and other exclusions from coverage under this Policy, refer to the section titled, "***Exclusions and Limitations.***"

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

You may also request an expedited external review if a Final Adverse Determination concerns a denial of coverage based on the determination that the treatment or service in question is considered Experimental or Investigational and your health care Provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

Expedited external review will not be provided for retrospective adverse or final adverse determinations.

Your request for an expedited independent external review may be submitted to the IDOI either orally (by calling the phone number) or in writing as set forth above for requests for standard external review.

7. **Notification**. Upon receipt of a request for an expedited external review, the IDOI shall immediately send a copy of the request to the Plan. The Plan shall immediately notify the IDOI, you and your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review. The Plan's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the IDOI's decision shall be in accordance with the terms of the benefit program (unless such terms are inconsistent with applicable law) and shall be subject to all applicable laws.

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

   Upon receipt from the IDOI of the name of the IRO assigned to conduct the external review, the Plan or its designated utilization review organization shall immediately, (but in no case more than 24 hours after receiving such notice) provide to the assigned IRO the documents and any information considered in making Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may submit additional information in writing to the assigned IRO within 24 hours or additional information may accompany the request for an expedited independent external review. If the Plan or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the external review, the IRO shall notify the IDOI, the Plan, you and, if applicable, your authorized representative, of its decision to reverse the determination.

   As expeditiously as your medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited external review), the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the IDOI, the Plan, you and, if applicable, your authorized representative. If the initial notice regarding its determination was not

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in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the IDOI, the Plan and, if applicable, your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of Experimental or Investigational treatments, each clinical reviewer shall provide an opinion orally or in writing to the assigned IRO as expeditiously as your medical condition or circumstances requires, but in no event 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 Plan, you and your authorized representative, if applicable.

If the IRO's initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the IDOI, the Plan and, if applicable, your authorized representative.

The assigned IRO is not bound by any decisions or conclusions reached during the Plan's utilization review process or the Plan's internal appeal process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance's Office of Consumer Health Insurance.

An external review decision is binding on the Plan. An external review decision is binding on you, except to the extent you have other remedies available under applicable federal or state law. You and your authorized representative may not file a subsequent request for external review involving the same Adverse Determination or Final Adverse Determination for which you have already received an external review decision.

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Expedited External Review

Expedited External Review	Timing
You may file a request for an expedited external review after the date of receipt of a notice prior to Final Adverse Determination:	immediately
You may file a request for an expedited external review if the Plan fails to provide a decision on a request for an expedited internal appeal within:	48 hours
The Plan must immediately notify the IDOI, you or your authorized representative whether the request is complete and eligible for an expedited external review or is ineligible for review and may be appealed to the IDOI. The IDOI may make a determination that the request is eligible for an expedited external review, notwithstanding the Plan's determination.	
The IDOI shall assign an independent review organization (IRO):	immediately
The Plan shall provide all necessary documents and information to the IRO:	immediately, but not more than 24 hours after assignment of an IRO
If the Plan fails to provide the necessary documents and information within the required time mentioned above, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination.	
The IRO shall provide notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination to the Plan, the IDOI and you or your authorized representative:	as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the receipt of request.

External Review of Experimental or Investigational Treatment

Experimental or Investigational Treatment External Review	Timing
You may file a request with the IDOI for an external review after receipt of an Adverse Determination or a Final Adverse Determination within:	4 months after date of receipt
If your treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may make an oral request for an expedited external review, after which the IDOI shall immediately notify the Plan and the time frames otherwise applicable to Expedited External Review shall apply.	
After the receipt for an external review, the IDOI shall send a copy of the request to the Plan within:	one business day
The Plan shall complete a preliminary review of the request within:	5 business days
After completion of the preliminary review, the Plan shall notify you or your authorized representative and the IDOI whether the request is complete and eligible for external review within:	one business day

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When the IDOI receives notice that the request is eligible for external review, the IDOI shall:	
assign an IRO and notify the Plan of the name of the IRO, within:	one business day
notify you or your authorized representative in writing of the request's eligibility and acceptance for external review and the name of the IRO, within:	one business day
If you are notified that your request for an external review has been accepted, you or your authorized representative may submit additional information to the assigned IRO within:	5 business days
The assigned IRO shall then select one or more clinical reviewers within:	one business day
The Plan shall provide the assigned IRO the documents and any information used in making the Adverse Determination or Final Adverse Determination within:	5 business days of notice of assigned IRO
After being selected by the assigned IRO, each clinical reviewer shall provide an opinion to the assigned IRO on whether the recommended or requested health care service shall be covered within:	20 days
or, in the case of an expedited external review:	immediately, but in no event more than 5 calendar days
The assigned IRO shall make a decision after receipt of the opinion from each clinical reviewer and provide notification of the decision to the IDOI, you or your authorized representative and the Plan within:	20 days
or, in the case of an expedited external review, within:	48 hours after receipt of the opinion of each clinical reviewer

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OTHER THINGS YOU SHOULD KNOW

THIRD PARTY RECOVERY

The Plan is assigned the right to recover for a sickness or injury from a third party, or his or her insurer, only to the extent of the benefits paid by the Plan for such sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Plan may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Plan has contracts with certain Providers and other suppliers of goods and services for the provision of and/or payment for health care goods and services to all persons entitled to health care benefits under individual and group policies or contracts to which the Plan is a party, including all persons covered under your Group's Policy.

Under certain circumstances described in its contracts with such Providers and suppliers, the Plan may:

1. Receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which the Plan was obligated to pay the Provider or supplier.
2. Pay Providers or suppliers substantially less than their Claim Charges for goods or services, by discount or otherwise; or
3. Receive from Providers or supplier's other substantial allowances under the Plan's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximum amounts or any maximum amounts of benefits payable by the Plan under this Certificate and the calculation of all required deductible and Coinsurance amounts payable by you under this Certificate shall be based on the Provider's 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 the Plan 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 the Plan's separate financial arrangements with Providers work, please consider the following example:

1. 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?
2. You personally will have to pay the deductible and Coinsurance amounts set out in your Certificate.
3. 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 Provider's 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.
4. 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.
5. After taking into account the deductible and Coinsurance amounts, the Plan will satisfy its portion of the Hospital bill. In most cases, the Plan has a contract with Hospitals that allows it to pay less, and requires the Hospital to

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accept less than the amount of money the Plan 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 the Plan has to satisfy the rest of the Hospital bill, or $860. The Plan 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. The Plan receives, and keeps for its own account, the difference between the $860 bill and whatever the Plan ultimately pays under its contracts with Plan Providers, and neither you nor your Group are entitled to any part of these savings.

Your Group understands that the Plan may receive such payments, discounts, and/ or other allowances during the term of the Policy.

Neither you nor your Group are entitled to receive any portion of any such payments, discounts, and/or other allowances. Any Copayments and/or deductibles payable by you are pre-determined fixed amounts, based upon the selected benefit Plan, which are not impacted by any discounts or contractual allowances which the Plan may receive from a Provider.

Out-of-Area Services

Overview

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 work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside of BCBSIL's service area, the claim for those services may be processed through one of these Inter-Plan Programs.

When you receive care outside of BCBSIL's service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. BCBSIL explains how BCBSIL pays both kinds of providers below.

BCBSIL covers only limited healthcare services received outside of BCBSIL's service area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care, urgent care and follow up care obtained outside the geographic area BCBSIL serves. Any other services will not be covered when processed through any Inter-Plan Programs, unless authorized by your primary care physician ("PCP")/BCBSIL.

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.

Inter-Plan Programs

Under the Inter-Plan Programs, when you receive Out-of-Area 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.

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However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Inter-Plan Programs enable you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the copayment amount, as stated in your plan summary.

Emergency Care Services: If you experience a medical emergency while traveling outside BCBSIL's service area, go to the nearest emergency or urgent care facility.

When you receive Out-of-Area Covered Healthcare Services outside BCBSIL's service area and the claim is processed through Inter-Plan Programs, the amount you pay for the Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

1). The billed charges for your Out-of-Area Covered Healthcare Services; or

2). 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 healthcare 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 modifications 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.

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.

Nonparticipating Providers Outside BCBSIL's Service Area

Member Liability Calculation

When Out-of-Area Covered Healthcare Services are provided outside of BCBSIL's service area by nonparticipating providers, the amount(s) you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state 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 Out-of-Area Covered Healthcare Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

In certain situations, BCBSIL may use other payment methods, such as billed charges for Out-of-Area 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 Out-of-Area Covered Healthcare Services as set forth in this paragraph.

Blue Cross Blue Shield Global® Core (Blue Cross Blue Shield Global Solutions℠)

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General Information

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, (hereinafter: "domestic 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 Inter-Plan Programs available in the domestic 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 domestic 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 United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, 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, will arrange a physician appointment or hospitalization, if necessary.

1. Inpatient Services

In most cases, if you contact the service center for assistance, hospitals outside the domestic service area 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 initiate claims processing. However, if you paid in full at the time of service, you must submit a claim to obtain reimbursement for covered healthcare services.

2. Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the domestic 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.

3. Submitting a Blue Cross Blue Shield Global® Core Claim

When you pay for covered healthcare services outside the domestic 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.

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Plan's Separate Financial Arrangements with Prescription Drug Providers

The Plan hereby informs you that it has 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 the Plan is a party, including all persons covered under this Certificate. Under its arrangements with Participating Prescription Drug Providers, the Plan may receive from these Providers discounts for prescription drugs

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dispensed to you. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

Coinsurance amounts payable by you under this Certificate will be calculated on the basis of the Provider's Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider and the Plan for a prescription drug, whichever is lower.

To help you understand how the Plan's separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

1. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is $100. How is the $100 paid?
2. You personally will have to pay the Coinsurance amount set out in this Certificate.
3. However, for purposes of calculating your Coinsurance amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 prescription drug bill would be reduced by 20% to $80 for purposes of calculating your Coinsurance amount.
4. In our example, if your Coinsurance obligation is 25%, you personally will have to pay 25% of $80, or $20. You should note that your 25% Coinsurance is based upon the discounted amount of the prescription and not the full $100 bill.

For the mail order prescription drug program and specialty Pharmacy program partially owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail order prescription drug program and/or specialty Pharmacy program. The Plan pays a fee to Prime for Pharmacy benefit services. A portion of Prime's PBM fees is tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and home delivery processing.

“Weighted Paid Claim" refers to the methodology of counting Claims for purposes of determining the Plan's fee payment to Prime. Each retail (including Claims dispensed through PBM's specialty Pharmacy program) paid Claim will be weighted according to the days' supply dispensed. A paid Claim is weighted in 34-day supply increments, so a 1-34 days' supply is considered 1 weighted Claim, a 35-68 days' supply is considered 2 weighted Claims, and the pattern continues up to 6 weighted Claims for 171 or more days' supply. The Plan pays Prime a Program Management Fee (“PMF”) on a per weighted Claim basis.

The amounts received by Prime from the Plan, Pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a Claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Plan (as described above), administrative fees charged by Prime to Pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Certificate. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 5.5% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of the Plan and other Blue Plan operating divisions.

PLAN’S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

The Plan owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Plan has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as “Pharmacy Benefit Managers”) to provide, on the Plan's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using

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their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Plan. Neither the Group nor you are entitled to receive any portion of such rebates, except to the extent they may be figured into the pricing of the product. The Pharmacy Benefit Manager may share a portion of those rebates with the Plan.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

All benefit payments may be made by the Plan directly to any Provider furnishing the Covered Services for which such payment is due, and the Plan is authorized by you to make such payments directly to such Providers. However, the Plan reserves the right to pay any benefits that are payable under the terms of this Certificate directly to you, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by the Plan sufficiently in advance of the Plan's benefit payment. The Plan reserves the right to require submission of a copy of the Assignment of Benefit Payment.

You will not receive any notices regarding Covered Services received from your Primary Care Physician (or other Providers who are part of your Participating IPA/Participating Medical Group) because Claims do not have to be filed for those services.

Once Covered Services are rendered by a Provider, you have no right to request that the Plan does not pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Plan will have no liability to you or any other person because of its rejection of such request.

Except for the assignment of benefit payment described above, neither this Certificate nor an Enrollee's Claim for payment of benefits under this Certificate is assignable to any person or entity at any time, and coverage under this Certificate is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage.

FEDERAL BALANCE BILLING AND OTHER PROTECTIONS

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for Plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Illinois law, if there is a conflict between the terms of this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section and the terms in the rest of this Certificate, the terms of this section will apply. However, definitions set forth in the **FEDERAL NO SURPRISES ACT DEFINITIONS** provision of this section are for purposes of this section only.

1. PCP Selection

The Plan requires the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family Members. Until you make this designation, Blue Cross and Blue Shield of Illinois designates one for you. For information on how to select a PCP and for a list of participating PCPs, contact BCBSIL at www.bcbsil.com or customer service at the toll-free number on the back of your identification card. For Dependent children, you may designate any Participating Provider who specializes in pediatric care as their Primary Care Physician (PCP).

2. OB/GYN Care

You are not required to obtain a referral or authorization from your Primary Care Physician (PCP) or Women's Principal Health Care Provider (WPHCP) before obtaining Covered Services from any Participating Provider specializing in obstetrics or gynecology. However, before obtaining Covered obstetrical or gynecological care, the Provider must comply with certain policies and procedures required by your Plan, including Prior Authorization and

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referral policies. For a list of Participating Providers who specialize in obstetrics or gynecology, visit www.bcbsil.com or contact customer service at the toll-free number on the back of your identification card.

3. Continuity of Care

If you are under the care of a Participating Provider as defined in this Certificate who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

a. You are undergoing a course of treatment for a serious and complex condition,
b. You are undergoing institutional or inpatient care,
c. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
d. You are pregnant or undergoing a course of treatment for your pregnancy, or
e. You are determined to be terminally ill.

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

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

4. Federal No Surprises Act Definitions

The definitions below apply only to this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section. To the extent the same terms are also defined in the **DEFINITIONS** section of this Certificate, those terms will apply only to their use in the Certificate or this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section, respectively.

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

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

"**Emergency Services**" means, for purposes of this section only,

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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.

    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.

5. <u>Federal No Surprises Act Surprise Billing Protections</u>

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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 a Non-Participating Provider and BCBSIL and attempts to negotiate a payment resolution are unsuccessful within 30 days, the Non-Participating Provider or BCBSIL may initiate binding arbitration by filing a request with the Department of Insurance. The requesting party shall notify the non-requesting party that arbitration has been initiated, along with its final offer for settlement. The non-requesting party must also share its final offer with the requesting party before arbitration occurs. In the event there is still no resolution regarding the payment of services, the parties may move forward in the arbitration process with an impartial third-party arbiter pursuant to the provisions in 215 ILCS 5/356z.3a.

Cost-Sharing

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

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

For Included Services, these cost-share requirements will be counted toward your Participating Provider Deductible and/or Out-of-Pocket Limit, if any.

6. Federal No Surprises Act Prohibition of Balance Billing

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

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

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and

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may not ask you to give up your protections not to be balanced 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 balanced billed for these Air Ambulance Services.

COVERED SERVICES EXPENSE LIMITATION

If, during any calendar year, you have paid Copayments, deductibles and/or any Coinsurance amount for Covered Services under this Certificate the total amount of which equals the amount shown in the **BENEFIT HIGHLIGHTS** section of this Certificate, your benefits for any additional Covered Services that you may receive during that calendar year, including any Copayment, deductible and/or Coinsurance amounts, will be reimbursed by the Plan. Should the federal government adjust the deductible and/or out-of-pocket limit amount(s) for high deductible health Plans, the deductible and/or the out-of-pocket expense limit amount(s) in this Certificate will be adjusted accordingly.

In the event your Physician or the Hospital requires you to pay any additional Copayments, deductible and/or Coinsurance amounts after you have met the above provision, upon receipt of properly authenticated documentation, the Plan will reimburse to you the amount of those Copayments, deductibles and/or Coinsurance amounts.

The above Covered Services expense limitation provision does not include the following:

1. Services, supplies or charges limited or excluded under this Certificate; and
2. Expenses are not covered because a benefit maximum, if any, has been reached.

YOUR PROVIDER RELATIONSHIPS

The choice of a Hospital, Participating IPA, Participating Medical Group, Primary Care Physician or any other Provider is solely your choice, and the Plan will not interfere with your relationship with any Provider.

The Plan does not itself undertake to provide health care services, but solely to arrange for the provision of health care services and to make payments to Provides for the Covered Services received by you. The Plan is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Plan. Any contractual relationship between a Physician and a Hospital or other Provider should not be construed to mean that the Plan is providing professional service.

Each Provider provides Covered Services only to Enrollees and does not deal with or provide any services to any Group (other than as an individual Enrollee) or any Group's ERISA Health Benefit Program.

FAILURE OF YOUR PARTICIPATING IPA OR PARTICIPATING MEDICAL GROUP TO PERFORM UNDER ITS CONTRACT

Should your Participating IPA or Participating Medical Group fail to perform under the terms of its contract with the Plan, or fail to renew such contract, the benefits of this Certificate will be provided for you for Covered Services received from other Providers limited to Covered Services received during a thirty-day period beginning on the date of the Participating IPA's/Participating Medical Group's failure to perform or failure to renew its contract with the Plan. During this 30-day period, you will have the choice of transferring your enrollment to another Participating IPA or Participating Medical Group or of transferring your coverage to any other health care coverage then being offered by your Group to its members. Your transferred enrollment or coverage will be effective thirty-one days from the date your Participating IPA or Participating Medical Group failed to perform or failed to renew its contract with the Plan.

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ENTIRE POLICY

The Group Policy, including the Certificate, any Addenda, the Exchange application of the Group for Policy and the individual applications, if any, of the Enrollees constitutes the entire contract of coverage between the Group and the Plan. No change in the Group Policy shall be valid until approved by an executive officer of the Plan and unless such approval is endorsed here on or attached hereto.

AGENCY RELATIONSHIPS

Your Group is your agent under this Certificate. Your Group is not the agent of the Plan.

If the Policy is purchased through the Exchange, in no event shall the Plan be considered the agent of the Exchange or be responsible for the Exchange. All information you provide for the Exchange and received by the Plan from the Exchange will be relied upon as accurate and complete. The Group and/or participant will promptly notify the Exchange and Plan of any changes to such information.

CONTINUITY OF CARE

If you are under the care of a Primary Care Physician or a Women's Principal Health Care Provider or other Provider who leaves the Plan's network (for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by State licensing board), and your Provider agrees, you may be able to continue receiving Covered Services with that Provider.

for the following:

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

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 from the date of the notice to the Eligible Person of the Provider's termination from the network Plan, or if the Enrollee has entered the second or third trimester of pregnancy at the time of the Provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery.

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

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

NOTICES

Any information or notice which you furnish to the Plan under this Certificate must be in writing and sent to the Plan at its offices at 300 East Randolph Street, Chicago, Illinois, 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which the Plan furnishes to you must be in writing and sent to you at your address as it appears on the Plan's records or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Plan's records. The Plan may also provide such notices electronically, to the extent permitted by applicable law.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate until at least 60 days have elapsed since a Claim has been furnished to the Plan in accordance with the requirements of this Certificate. In addition, no such action may be brought once three years have elapsed from the date that a Claim is required to be furnished to the Plan in accordance with the requirements of this Certificate.

WELLNESS PROGRAMS

The Plan 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 telephonically by calling the toll-free telephone

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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.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this Certificate, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Certificate shall be used to void the Certificate or to deny a Claim for illness or injury beginning after the expiration of such two-year period.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan shall, at its own expense, have the right and opportunity to examine the person of an Enrollee when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

PROHIBITION AGAINST SUBSTITUTION

The Plan cannot require you to substitute your Primary Care Physician during any Inpatient Hospital stay, such as with a hospitalist Physician who is licensed to practice medicine in all its branches without the authorization of your Primary Care Physician.

MODIFICATION OF COVERAGE

The Plan may modify your Certificate as required or permitted by applicable law and may modify your Certificate at renewal as long as the modification is consistent with applicable state and federal law on a uniform basis. Should the Plan elect to uniformly modify, terminate or discontinue coverage under this Certificate, the Plan must provide 90 days advance notice to the Department of Insurance.

MEDICALLY NECESSARY DISPUTE RESOLUTION

A dispute resolution process must be established in which a Physician, holding the same class of license as your Primary Care Physician, but not affiliated with either your Participating IPA or Participating Medical Group, and is jointly selected by you and/or your Participating IPA or Participating Medical Group in the event of a dispute regarding the medical necessity of a service. The Plan shall be required to provide the services should the reviewing Physician determine services to be Medically Necessary.

INFORMATION AND RECORDS

You agree that it is your responsibility to 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 indemnification on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Plan or its agent, and agrees that any such Provider, person, or other entity may furnish to the Plan or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Plan may furnish similar information and records (or copies of records) to Providers, other Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance type benefits requesting the same. It is also your responsibility to furnish the Plan and/or your employer or Group Administrator information regarding you or your Dependents becoming eligible for Medicare, termination of Medicare eligibility, or any change in Medicare eligibility status, in order that the Plan be able to make Claim Payments in accordance with MSP laws.

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QUALIFIED HEALTH PLAN ACTUARIAL VALUE

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.

MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, by the Host Blues whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by your Group, but solely as a result of a reduction in force, plant/office closing(s) or group health plan termination. As part of the overall plan of benefits that Blue Cross and Blue Shield of Illinois offers to, you, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, Blue Cross and Blue Shield of Illinois may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Policy the Group has with Blue Cross and Blue Shield of Illinois to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

OVERPAYMENT

If the Plan pays benefits for eligible expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error (“Overpayment”), the Plan has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any other insurance company or plan, or (iii) any other persons, entity or organization.

If no refund is received, the Plan may deduct any refund due to it from:

1. Any future benefit payment owed to any person or entity under this Certificate, whether for the same or a different member.
2. Any future benefit payment owed to any person or entity under another Plan administered Administrative Service Only (“ASO”) benefit program.
3. Any future benefit payment made owed to any person or entity under another Plan insured group benefit Plan or individual policy.
4. Any future payment, or other payment, owed to any person or entity; or,
5. Any future payment owed to one or more participating Providers or non-participating Providers.

Further, the Plan has the right to reduce your benefit Plan or policy’s payment to a Provider by the amount necessary to recover another Plan’s or policy’s Overpayment to the same Provider and to remit the recovered amount to the other Plan or policy.

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DEFINITIONS

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. The definitions of these words are listed below in alphabetical order. **These defined words will always be capitalized when used in this Certificate.**

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

Acute Treatment Services – Means 24-hour Medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

Ambulatory Surgical Facility – Means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services, when operating within the scope of such license.

Ambulance Transportation – Means a Medically Necessary local transportation service in specially equipped certified ground and air transportation options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. 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 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.

Approved Clinical Trial – Means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is one of the following:

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

Autism Spectrum Disorder(s) – Means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including Asperger's disorder and pervasive developmental disorders not otherwise specified.

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

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the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under this Certificate are secondary to Medicare and/or coverage under any other group program.

Behavioral Health Practitioner – Means a Physician or professional Provider who is duly licensed to render services for the treatment of Mental Illness or Substance Use Disorder treatment.

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.

Calendar Year or calendar year – Means a 12-month period starting January 1 of each year, however the first calendar year for purposes of benefits under this policy begins on the Enrollment Date and ends on December 31st of that year.

Certificate – Means this booklet and your application for coverage under the Plan benefit program described in this booklet.

Certified Clinical Nurse Specialist – Means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and Hospital referral and (c) meets the following qualifications:

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

Certified Nurse Midwife – Means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (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 meets the following qualifications:

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

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

Chemotherapy – Means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Chiropractor – Means a duly licensed chiropractor.

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

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

Claim Charge – Means the amount which appears on a Claim as the Provider's or supplier's charge for goods or services furnished to you, without adjustment or reduction and regardless of any separate financial arrangement between the Plan and a particular Provider or supplier. (See provisions of this Certificate regarding Plan's Separate Financial Arrangements with Providers.")

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

Clinical Appeal – Means an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care Provider that do not meet the definition of an Urgent/Expedited Clinical Appeal.

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

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

Coinsurance – Means a Copayment that is a percentage of an eligible expense that you are required to pay towards a Covered Service.

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**.**

Coordinated Home Care Program – Means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.)

Congenital or Genetic Disorder – Means a disorder that includes, but is not limited to hereditary disorders, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

Continuous Ambulatory Peritoneal Dialysis Treatment – Means a continuous dialysis process using a patient's peritoneal membrane as a dialyzer.

Copayment – Means a specified dollar amount or Coinsurance that you are required to pay towards a Covered Service.

Coverage Date – Means the date on which your coverage under this Certificate begins.

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Covered Service – Means a service or supply specified in this Certificate for which benefits will be provided.

Custodial Care Service – Means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills or professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications etc.) and are to assist with activities of daily living, (e.g. bathing, eating, dressing, etc.).

Dentist – means a duly licensed dentist.

1. A **"Participating Dentist"** means a Dentist who has a written agreement with the Plan, or the entity chosen by the Plan to administer a Participating Provider Option Dental program to provide services to you at the time you receive the services.
2. A **"Non-Participating Dentist"** means a Dentist who does not have a written agreement with the Plan, or the entity chosen by the Plan to administer a Participating Provider Option Dental program to provide services to participants in the Participating Provider Option program.

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 Mammograms – Means a mammogram obtained using Diagnostic Mammography.

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

Diagnostic Service – means tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, peripheral artery disease screening, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, computerized tomography ("CT scans"), magnetic resonance imaging ("MRI") and positron emission tomography ("PET scans")

Dialysis Facility – Means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

Domestic Partner – Means a person with whom you have entered into a Domestic Partnership.

Domestic Partnership – Means a long-term committed relationship of in-definite duration with a person which meets the following criteria:

1. You and your Domestic Partner have lived together for at least six months.
2. Neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner.
3. Both you and your Domestic Partner are at least 18 years of age and mentally competent to consent to contract.
4. You and your Domestic Partner reside together and intend to do so indefinitely.
5. You and your Domestic Partner have an exclusive mutual commitment similar to marriage; and

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6. You and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

Drug List – Means a list of pharmaceutical products that are available to members, Physicians or other health care Providers for purposes of providing information about the coverage and tier status of individual pharmaceutical products.

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

Electroconvulsive Therapy – Means a medical procedure in which a brief application of an electric stimulus is used to produce a generalized seizure.

Eligible Charge – Means in the case of a Provider other than a Physician, which has a written agreement with the Plan or another Blue Cross and/or Blue Shield Plan to provide care to participants in the health care Plan, or is designated as a participating Provider by any Blue Cross and/or Blue Shield Plan, at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services.

In addition to the foregoing, the Eligible Charge will be subject in all respects to the Plan's Claim Payment rules, edits and methodologies regardless of the Provider's status as a participating Provider or non-participating Provider. Please refer to the "Plan's Separate Financial Arrangements with Providers" provision in the **OTHER THINGS YOU SHOULD KNOW** section of this Certificate.

Eligible Person – Means an employee of the Group who meets the eligibility requirements for this health coverage, as described in the **ELIGIBILITY** section of this Certificate.

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

1. Placing the health of the individual (or, with respect to a pregnant individual, the health of the individual or unborn child) in serious jeopardy.
2. Serious impairment to bodily functions; or
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 individual or unborn child

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

Emergency Mental Illness or Substance Use Disorder Admission – Means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorders condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

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Emergency Services – Means with respect to an Enrollee of a health care Plan, transportation services, including but not limited to ambulance services, and covered Inpatient and Outpatient Hospital services furnished by a Provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Medical Condition.

Enrollee – Means the person who has applied for coverage under this Certificate and to whom the Plan has issued an identification card.

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

Experimental/Investigational (also referred to as "Investigational") – Means the use of any treatment, procedure, facility, equipment, drug, device, or supply (including emerging technologies, services, procedures, and service paradigms) not accepted as "Standard Medical Treatment" of the condition being treated or any of such items requiring federal or other governmental agency approval not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

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

"Standard medical treatment**"** means the services or supplies that are in general use in the medical community in the United States, and.

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

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

Family Coverage – Means coverage for you 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 the Plan and has its own billing number and written agreement with the Plan to provide services to participants in the benefit program at the time Covered 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 of Illinois and the Group, any addenda, this Certificate, along with any exhibits, appendices, addenda and/or other required information and the individual application(s) of the persons covered under the Policy.

Habilitative Services – Means Occupational Therapy, Physical Therapy, Speech Therapy and other health care services that help an Eligible Person keep, learn, or improve skills and functioning for daily living, as prescribed by your Physician pursuant to a treatment Plan. Examples include Therapy for a child who isn't walking or talking at the expected age and

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includes therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for an Eligible Person with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this Certificate.

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

Hearing Care Professional – Means a person who is a licensed Hearing Aid dispenser, licensed audiologist, or licensed Physician operating within the scope of such license.

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.

Hospice Care Program – Means a centrally administered program designed to provide physical, psychological, social and spiritual care for terminally ill persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program service is available in the home, or in Inpatient Hospital or Skilled Nursing Facility special hospice care unit.

Hospice Care Program Provider – Means an organization duly licensed to provide Hospice Care Program service.

Hospital – Means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

Iatrogenic Infertility – Means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment, affecting reproductive organs or processes.

Individual Coverage – Means that your application for coverage was only for yourself.

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 your condition is so severe that it cannot be treated effectively by oral medications. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

In Home Health Assessment – Means benefits are available for an annual home health assessment. Covered Services may include, but are not limited to, health history and blood pressure 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.

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Benefits for the in-home health assessment will not be subject to any deductible, Copayment or Coinsurance when received from your Primary Care Physician or Woman's Principal Health Care Provider.

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

Life Threatening Disease or Condition – Means for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Long-Term Antibiotic Therapy – Means the administration of oral, intramuscular, or intravenous antibiotics singly or in combination for periods of time in excess of 4 weeks.

Long Term Care Services – Means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

Maintenance Care – Means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy – Means therapy administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Marriage and Family Therapist – Means a duly licensed marriage and family therapist operating within the scope of such license.

Medical Care – Means the ordinary and usual professional services rendered by a Physician, Behavioral Health Practitioner, or other specified Provider during a professional visit, for the treatment of an illness or injury.

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.

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

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

Mental Health Condition – 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.

Naprapathic Services – Means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

Network Service Area – Means the geographic area designated by BCBSIL, within which the Benefits of this Plan are available to Members. This Plan accepts Members if they reside, live or work in the geographic Network Service Area. In addition, routine non-Emergency services are generally limited to Providers within the service area. A Member may call the Customer Service Department at the number shown on the identification card or visit the website at www.bcbsil.com to determine if he or she is in the Network Service Area.

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Non-Clinical Appeal – Means an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

Occupational Therapy – Means a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

Ongoing Course of Treatment – Means see provision for "Continuity Of Care."

Optometrist – Means a duly licensed optometrist.

Outpatient – Means that you are receiving treatment while not an Inpatient.

Partial Hospitalization Treatment Program – Means a Participating IPA/Participating Medical Group, 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 of Illinois 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 of Illinois as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Participating IPA – Means any duly organized Individual Practice Association of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

Participating Medical Group – Means any duly organized group of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

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 need, and coordination of care. Pediatric Palliative Care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person-centered and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness. Through early integration into the care Plan for the seriously ill, palliative care improves quality of life for the patient and the family. Palliative care can be offered in all care settings and at any stage in a serious illness through collaboration of many types of care Providers.

Pharmacy – Means a state and federally licensed establishment where the practice of Pharmacy occurs, that is physically separate and apart from any Providers office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

Physical Therapy – Means the treatment by physical means by or under the supervision of a qualified physical therapist.

Physician – Means a Physician duly licensed to practice medicine in all of its branches.

Physician Assistant – Means a duly licensed Physician assistant performing under the direct supervision of a Physician.

Plan – 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 of which Blue Precision HMO SM is a product line.

Podiatrist – Means a duly licensed podiatrist.

Policy – Means the agreement between the Plan and the Group, including the Certificate, any addenda or riders that apply, the Benefit Program Application and the individual applications, if any, of the persons covered under the Policy.

Preferred Drug – Means either a brand name prescription drug that has been designated as a preferred drug by the Plan or any generic prescription drug. The listing of drugs designated as being Preferred Drugs may be amended from time to time by the Plan.

Prescription Drug Provider– Means any Pharmacy which regularly dispenses drugs.

1. 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 or retail Pharmacies, home delivery Pharmacy or Specialty Drug Pharmacy Provider that has a written agreement with the Plan, or with the entity chosen by the Plan to administer its prescription drug program, to provide Covered Services at the time rendered.
2. non-participating Prescription Drug Provider or non-participating Pharmacy Provider– means a Pharmacy, including but not limited to, an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or Specialty Drug Pharmacy Provider which (i) has not entered into a written agreement with the Plan or (ii) has not entered into a written agreement with any entity chosen by the Plan to administer it's prescription drug program, for such Pharmacy to provide pharmaceutical services at the time Covered Services are rendered.

Primary Care Physician (PCP) – Means a Provider who is a member or Eligible Person of or who is affiliated with or engaged by a Participating IPA or Participating Medical Group and who is a) a Physician who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics, psychiatry, or family practice, or b) a Chiropractor, and who you have selected to be primarily responsible for assessing, treating or coordinating your health care needs.

Private Duty Nursing Service – Means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing Service does not include Custodial Care Service.

Provider – Means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician, 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.

Provider's Charge – Means a) in the case of your Primary Care Physician or another Physician who is affiliated with your Participating IPA/Participating Medical Group, the amount that such Physician would have charged for a good or service had you not been enrolled under this benefit program or b) in the case of a Provider or supplier which is not affiliated with your Participating IPA/Participating Medical Group, such Provider's or supplier's Claim Charge for Covered Services, unless otherwise agreed to by the Plan and the Provider or supplier.

Psychologist – Means:

1. A Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologist Registration Act" (111 Ill. Rev. Stat. §5301 et seq., as amended or substituted); or
2. In a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice; or
3. If practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Substance Use Disorder and who meets the following qualifications:
    a. Has a doctoral degree from a regionally accredited University, College, or Professional School and has two years of supervised experience in health services of which at least one year is postdoctoral and one year in an organized health services program; or

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b. Is a registered Clinical Psychologist with a graduate degree from a regionally accredited University or College and has not less than six years' experience as a psychologist with at least two years of supervised experience in health services.

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

For the treatment supervisor / case manager / facilitator:

1. Master's level, independently licensed Clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided, for services treating Autism Spectrum Disorder (ASD) symptoms, with or without applied behavior analysis (ABA) service techniques; or
2. Master's level Clinician whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e., Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst –Doctoral (BCBA-D) to supervise and provide treatment planning, with ABA service techniques; or
3. 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 an MD order for services to be provided by a specific person.

For the para-professional / line therapist:

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

Qualified Employee – Means an individual employed by a Qualified Employer who has been offered health insurance coverage by such Qualified Employer through the Small Business Health Option Program.

Qualified Employer – Means a Small Employer that elects to offer, at a minimum, all full-time Eligible Person of such Employer coverage in one or more Qualified Health Plans offered through the SHOP. Beginning in 2017, if a state allows large employers to purchase coverage through the SHOP, the term "Qualified Employer" shall include a large employer that elects to make all full-time employees of such Eligible Persons eligible for one or more QHPs in the large group market offered through the SHOP.

Qualified Health Plan or QHP – Means a health care benefit program that has in effect a certification that it meets the applicable government standards.

Qualified Health Plan Issuer or QHP Issuer – Means a health insurance issuer that offers a QHP.

Radiation Therapy – Means the use of ionizing radiation in the treatment of a medical illness or condition.

Rescission – Means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums. A "Rescission" does not include other types of coverage cancellations, such as a

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cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

Renal Dialysis Treatment – Means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

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

Respite Care Services – Means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services for you.

Routine Patient Costs – Means the cost for all items and services consistent with the coverage provided under this Certificate, that is typically covered for an Eligible Person who is not enrolled in a clinical trial.

Routine Patient Costs do not include:

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

SHOP – Means a Small Business Health Option Program (“SHOP”) through which a Qualified Employer can provide its Eligible Persons and their Dependents with access to one or more QHPs.

Skilled Nursing Facility – Means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

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

Small Employer – Means in connection with a group health Plan with respect to a calendar year and a Plan year, an employer who employed an average of at least 1 but not more than 50 Eligible Persons on business days during the preceding calendar year and who employs at least 1 Eligible Persons on the first day of the Plan year.

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Specialist Physician – Means a Provider with a contractual relationship or affiliation with the Participating IPA/Participating Medical Group who does not meet the definition of a Primary Care Physician, Woman's Principal Health Care Provider, or Behavioral Health Practitioner.

Speech Therapy – Means treatment for the correction of a speech impairment, including pervasive developmental disorders.

Standard Fertility Preservation Services – Means procedure based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

Standard Medical Treatment – Means the services or supplies that are in general use in the medical community in the United States, and.

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

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

Standing Referral – Means a written referral from your Primary Care Physician or Woman's Principal Health Care Provider for an Ongoing Course of Treatment pursuant to a treatment Plan specifying needed services and time frames as determined by your Primary Care Physician or Woman's Principal Health Care Provider, the consulting Physician or Provider and the Plan.

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

Substance Use Disorder Treatment Facility – Means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and which is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

Surgery – Means the performance of any Medically recognized, non-Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations, and any other procedures as reasonably approved by the Plan.

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.

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

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

Tobacco Use Cessation Program – Means a program recommended by a Physician that follows evidence-based treatment, such as outlined in the United States Public Health Service guidelines to tobacco use cessation. "Tobacco Use Cessation Program" includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products. "Tobacco Use Cessation Program" includes education and counseling by Physicians or associated medical personnel and all FDA-approved medications for the treatment of tobacco dependence irrespective of whether they are available only over the counter, only by prescription, or both over the counter and by prescription. In addition, the Plan will communicate with you on an annual basis the importance and value of early detection and proactive management of cardiovascular disease.

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 an Enrollee 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.

Urgent/Expedited Clinical Appeal – Means an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatments ordered by a health care Provider that, if a decision is denied, may significantly increase the risk to your health.

Vitamin D Testing – Means vitamin D blood testing that measures the level of vitamin D in a person's blood.

Woman's Principal Health Care Provider (WPHCP) – Means a Physician licensed to practice medicine in all of its branches, specializing in obstetrics or gynecology or specializing in family practice.

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CONTINUATION COVERAGE FOR DISABLED OR RETIRED 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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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. Thissafety 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

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Illinois Department of Insurance 4th Floor

320 West Washington StreetSpringfield, Illinois 62767

Insurance companies, health maintenance organizations and agents are not allowed byIllinois 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)

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:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbsil.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

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中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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