BLUE MEDICARE SUPPLEMENT℠

MEDICARE SELECT PLAN G PLUS

Your Health Care Benefit Policy

BlueCross BlueShield of Illinois

Underwritten by HCSC Insurance Services Company

Medicare Supplement plans provided by Blue Cross and Blue Shield of Illinois, which refers to HCSC Insurance Services Company (HISC) an Independent Licensees of the Blue Cross and Blue Shield Association (hereinafter referred to as “Blue Cross and Blue Shield of Illinois” or “BCBSIL”).

300 East Randolph, Chicago, IL 60601

IL-GSP-HISC-2024

YOUR RIGHT TO EXAMINE

You have the right to examine this Policy for a 30-day period after it has been issued. If for any reason you are not satisfied with the Medicare Supplement Plus program described in this Policy, you may return this Policy to Blue Cross and Blue Shield of Illinois as long as you do so within 30 days of receipt and as long as you have not filed a claim. Blue Cross and Blue Shield of Illinois will refund any Medicare Supplement Plus Premiums you paid.

GUARANTEED RENEWABILITY

Blue Cross and Blue Shield of Illinois cannot cancel or refuse to renew this Policy for any reason other than non-payment of Medicare Supplement Plus Premiums or material misrepresentation. However, Blue Cross and Blue Shield of Illinois may change the amount of Medicare Supplement Plus Premiums due or automatically increase Medicare Supplement Plus Premiums based upon the Policyholder's age classification.

NOTICE TO BUYER

This Policy may not cover all of your medical expenses.

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A message to the Policyholder from

BLUE CROSS AND BLUE SHIELD OF ILLINOIS

Blue Cross and Blue Shield of Illinois agrees to pay certain Hospital, Skilled Nursing Facility, Physician and medical/surgical charges you incur provided you pay your Medicare Supplement Premiums for this coverage. This agreement is subject to all terms and conditions of this Policy.

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

This Policy will explain your Medicare Supplement Plus insurance. Be sure to read this Policy very carefully. It explains your rights and responsibilities and the rights and responsibilities of Blue Cross and Blue Shield of Illinois.

In this Policy, **you**, **your** and **yours** mean the Policyholder. That's the person insured by this Policy. **We**, **us**, and **our** mean Blue Cross and Blue Shield of Illinois.

This Policy, your application for coverage, and any endorsements or riders attached to this Policy make up your entire agreement with us.

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

Sincerely,

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

Stephen Harris, President Illinois Division

GLOSSARY

You, the Policyholder, are the only insured. You must be covered by Medicare. The definitions stated below will apply to the following terms when used in this Policy:

"**Accidental Injury**" means a bodily injury you receive as the direct result of an accident. An Accidental Injury cannot be the result of a disease or other bodily condition.

"**Assignment**" In the original Medicare plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the original Medicare plan, it can save you money if your doctor accepts Assignment. You still pay your share of the cost of the doctor's visit.

"**Calendar Year**" means the period commencing on January 1st and ending on the next succeeding December 31st, inclusive.

"**Calendar Year Deductible**" means the first dollar amount of your Part A and/or Part B charges incurred outside of the United States during a Calendar Year.

"**Coinsurance**" means the percentage of the Medicare approved amount that a Member pays after meeting the Medicare deductible.

"**Effective Date**" (also referred to as "Coverage Date") means the date that the Member is enrolled on our membership records for coverage under this Policy.

"**Emergency Care**" means care given for a medical emergency when you believe that your health is in danger when every second counts.

"**Excess Charges**" If you are in the original Medicare plan, this is the difference between a doctor or other health care Provider actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

"**Explanation of Medicare Benefits Form**" means the Medicare notice of what medical services or supplies were covered, what charges were approved, how much was credited toward the Part A or B deductible, and the amount that Medicare paid.

"**Foreign**" means any areas not included in the United States.

"**Grievance**" means a complaint about the way your Medicare health plan is giving care. For example, you may file a Grievance if you have a problem calling the plan or if you are unhappy with the way a staff person at the plan has behaved toward you. A Grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered.

"**Home Health Agency**" means an organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.

"**Home Health Care**" means limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, Hospital beds, oxygen, and walkers), medical supplies, and other services.

"**Hospice**" means a Medicare-certified program that provides care and support to terminally ill patients and their families.

"**Hospital**" means an institution primarily engaged in providing, by or under the supervision of a licensed Physician or a staff licensed Physicians, inpatient diagnostic and therapeutic services or rehabilitation services, as further described in the Section of this Policy entitled "What Inpatient Hospital Services are Covered".

“**Identification Card**” (ID Card) means the card BCBSIL issues identifying the Member as a BCBSIL Member. This card should be presented with your Medicare card whenever you receive health care services.

“**Inpatient Hospital Care**” means health care that you get when you are admitted to a Hospital.

“**Lifetime Reserve Days**” In original Medicare, these are additional days that Medicare will pay for when you’re in a Hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each Lifetime Reserve Day, Medicare pays all covered costs except for a daily Coinsurance.

“**Medicaid**” means a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

“**Medically Necessary**” means health care services or supplies needed to diagnose or treat a Sickness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine as set forth in this Policy under section “What Do We Mean By Medically Necessary”.

“**Medicare**” means the federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

“**Medicare Benefit Period**” means the way that original Medicare measures your use of Hospital and Skilled Nursing Facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a Hospital or SNF. The benefit period ends when you haven't gotten any Inpatient Hospital Care (or skilled care in a SNF) for 60 days in a row. If you go into a Hospital or a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

“**Medicare Eligible Expense**” means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

“**Medicare Part A Benefits**” means Hospital insurance that pays for inpatient Hospital stays, care in a Skilled Nursing Facility, Hospice care, and some Home Health Care.

“**Medicare Part B Benefits**” means Medicare medical insurance that helps pay for doctor’s services, Outpatient Hospital care, durable medical equipment, and some medical services that are not covered by Part A.

“**Medicare Select**” means a type of Medicare Supplement (also referred to as Medigap) policy that may require you to use Hospitals and, in some cases, doctors within its network to be eligible for full benefits.

“**Medicare Supplement**” is also referred to as a Medigap policy. It is sold by private insurance companies to fill "gaps" in original Medicare plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan N. Medigap policies only work with the original Medicare plan.

“**Medicare Supplement Benefits**” means payments for health care services provided to a Member according to the terms of this Policy.

“**Medicare Supplement Premium**” means the periodic payment to an insurance company or a health care plan for health or prescription drug coverage.

“**Member**” means the insured person who is eligible for coverage under this Policy.

“**Network Hospital**” means an eligible Hospital which has entered into a written agreement with the issuer to provide benefits covered under a Medicare Select policy.

“**Non-Network Hospital**” means an eligible Hospital which has not entered into a written agreement with the issuer to provide benefits covered under a Medicare Select policy.

“**Outpatient**” means medical or surgical care you get from a Hospital when your doctor hasn’t written an order to admit to the Hospital as an inpatient. Outpatient Hospital care may include emergency department services, observation services, Outpatient surgery, lab tests, or X-rays. Your care may be considered Outpatient Hospital care even if you spend the night at the Hospital.

“**Physician**” means any types of professionals that are legally authorized by the state to practice medicine, regardless of whether they are Medicare, Medicaid, or Children's Health Insurance Program (CHIP) Providers.

“**Policyholder**” means the person to whom this Policy is issued.

“**Provider**” means a general term for a person, practitioner, institution, or facility that is licensed by the state or jurisdiction where the treatment is given and is recognized by Medicare.

“**Service Area**” means a geographic area where a health insurance plan accepts Members if it limits membership based on where people live, as defined in your outline of coverage.

“**Sickness**” means illness or disease of an insured person which first manifests itself after the Effective Date of insurance and while the insurance is in force.

“**Skilled Nursing Facility**” means a nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

“**Tobacco User**” is 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 of four or more times per week that last occurred within the past six months. Tobacco products include but are not limited to: cigarettes, cigars, smokeless tobacco products, electronic cigarettes, dissolvable tobacco products and vaping.

“**United States**” means all of the states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

GENERAL INFORMATION ABOUT THIS POLICY

WHO IS COVERED BY THIS POLICY?

You, the Policyholder, are the only insured. You must be covered by Medicare Parts A and B. There is no family coverage.

WHEN DOES MY COVERAGE START AND END?

Coverage starts on your Effective Date (your ‘‘Coverage Date’’). However, inpatient benefits are covered only when your admission occurs on or after your Coverage Date. Your Coverage Date is shown on your ID Card. Your Medicare Supplement Premium must be paid before coverage can begin.

You may cancel at any time for any reason. Just send us written notice or call the number on the back of your ID Card. Your benefits will end on the date your Policy is cancelled.

We may cancel your Policy if:

- you don’t pay Medicare Supplement Premiums when due; or
- you make a material misrepresentation; or
- you are no longer eligible for Medicare Parts A and B.

We’ll send you written notice if your Policy is going to be cancelled.

NOTICE

Written notice to us must be sent to:

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

CAN YOU REINSTATE MY POLICY?

Yes. If we cancel your Policy because you don’t pay a Medicare Supplement Premium you may reapply. We will reinstate your Policy if the following conditions are met:

1. We accept your application, and
2. We bill you, and
3. You pay, and we accept the billed Medicare Supplement Premium.

However, we’ll only cover treatment for:

- Accidental Injuries received after the date we accept payment; and
- Sicknesses beginning more than 10 days after we accept payment.

WHAT DOES THIS POLICY COVER?

This Policy provides Hospital service benefits and medical/surgical coverage. Skilled Nursing Facility care is covered under the Hospital benefits.

Medical/surgical coverage includes Physician's visits. It also covers most Outpatient services.

WHAT IF I BECOME ELIGIBLE FOR MEDICAID?

If you become eligible for benefits under Medicaid, you may request that we suspend your coverage. You may request that we suspend your coverage by giving us written notice or calling within 90 days after the date you become eligible for Medicaid.

When we ''suspend coverage'' this means that we will no longer provide benefits under this Policy and will refund any portion of your unused Medicare Supplement Premium to you. **We will not suspend your coverage for more than 24 months.**

We will reinstate your coverage when your eligibility for benefits under Medicaid ends. However, you must give us written notice within 90 days after the date you lose your Medicaid eligibility. When we reinstate your coverage, your Medicare Supplement Premiums and benefits will be the same or similar to the Medicare Supplement Premiums and benefits you would have had if you had not suspended coverage under this Policy. You will not be subject to a pre-existing condition waiting period.

HOW DOES THIS POLICY SUPPLEMENT MEDICARE?

This Medicare Select Plan G is a full supplement to Medicare as defined in the Illinois Insurance Code. This Policy does not pay your Medicare Part A Deductible. However, you will not have to pay your Medicare Part A Deductible when Medicare-approved services are received in a Network Hospital.

This Policy does not pay your Part B Deductible. It pays the difference between remaining charges approved for payment by Medicare and the amount Medicare actually pays. This Policy will never duplicate Medicare benefits.

MEDICARE MUST APPROVE SERVICES

We only pay for services which have been approved by Medicare.

TERMINATION OF THIS POLICY DUE TO A CHANGE IN LAW

Medicare Supplement policies of this type are governed by a federal program. If that program is substantially modified or becomes invalid because of a change in law, the Secretary of Health and Human Services may require that all policies issued under the program be discontinued. In this event, your Policy will terminate. We'll notify you in writing of the termination.

You may then apply to continue coverage under any other Medicare Supplement Plus policy we offer which does not include the Medicare Select program but provides **comparable or lesser benefits**. You will not have to provide us proof that your health is acceptable for insurance.

A Medicare Supplement Plus policy is considered to have comparable or lesser benefits unless it provides coverage for one or more of the following benefits **not** included in this Policy:

- the Medicare Part A Deductible;

- prescription drugs;
- Part B Excess Charges.

WHAT IF I LATER WANT A DIFFERENT TYPE OF COVERAGE?

If you have been covered under this Policy for at least 6 months and decide you want coverage which:

- has comparable or lesser benefits (as described in the section above); and
- does not include the Medicare Select program,

you may then purchase any other Medicare Supplement policy we currently offer which meets your need.

When you apply for another policy, you will not have to provide us proof that your health is acceptable for insurance.

YOUR PART A SUPPLEMENT HOSPITAL BENEFITS

You're covered for Hospital stays. You're also covered for Skilled Nursing Facility stays. Remember, you're covered only for care that begins on or after your Coverage Date.

THE MEDICARE SELECT PROGRAM

We have arranged for the administration of your inpatient Hospital benefits through our Medicare Select program. Under this program, certain Hospitals have entered into a written agreement with us to provide services covered by this Policy. When you use the services of a Network Hospital, your benefits under this Policy will be greater.

As a participant in the Medicare Select program, you have received a directory of Network Hospitals. There may be changes in the directory listing. You will receive written notice of any changes to the Network Hospitals listed in the directory.

Although you may continue to go to the Hospital of your choice, remember that your benefits are greater when you use the services of a Network Hospital.

An applicant needs to live or reside in the Service Area in order to purchase this Policy.

WHAT DO WE MEAN BY "HOSPITAL"?

A Hospital is a properly licensed institution for care of the sick. It must:

- be supervised by a licensed Physician or staff of licensed Physicians;
- regularly provide bedside nursing by registered graduate professional nurses; and
- be approved by Medicare.

Rest homes or nursing homes are not considered Hospitals. Neither are institutions mainly offering:

- custodial, educational or rehabilitory care;
- care of the aged; or
- treatment for substance use disorder or alcoholism.

WHAT DO WE MEAN BY "SKILLED NURSING FACILITY"?

A Skilled Nursing Facility is a properly licensed institution, that:

- is approved for payment of Medicare benefits or qualified for approval of Medicare benefits;
- is supervised by a licensed Physician or a staff of licensed Physicians;
- provides 24-hour skilled nursing care by, or is supervised by, registered graduate nurses; and
- keeps a daily medical record for each patient.

Rest and retirement homes are not considered Skilled Nursing Facilities. Neither are institutions mainly offering:

- custodial or educational care;
- care of the aged;

- care and treatment of mental illness; or
- treatment for substance use disorder or alcoholism.

WHAT ARE MY HOSPICE AND INPATIENT RESPITE CARE BENEFITS?

Under this Policy:

- If the Member is receiving Hospice Care, Blue Cross and Blue Shield of Illinois will provide benefits for the cost sharing for all Part A Medicare Eligible Expenses and respite care expenses.
- We pay the cost of the Medicare Coinsurance/copayments.

WHAT ARE MY BENEFITS IN A NETWORK HOSPITAL?

You will not have to pay your Part A Deductible when Medicare-approved services are received in a Network Hospital. In addition, we will pay the copayments you owe from the 61st through the 150th day of a stay in a Network Hospital. We will also pay for an additional 365 days of benefits beginning on the 151st day of your stay in a Network Hospital.

NOTE: THE PART A DEDUCTIBLE IS SHOWN IN THE OUTLINE OF COVERAGE PROVIDED AT THE TIME YOU PURCHASED THIS POLICY. AS CHANGES OCCUR TO THIS DEDUCTIBLE, WE WILL SEND YOU NOTICE, ALONG WITH INFORMATION REGARDING ANY OTHER BENEFIT CHANGES AFFECTING THE COVERAGE UNDER THIS POLICY.

WHAT ARE MY BENEFITS IN A NON-NETWORK HOSPITAL?

When Medicare-approved services are received in a Non-Network Hospital, we will pay the copayments you owe from the 61st through the 150th day of the Non-Network Hospital stay. We will also pay for an additional 365 days of benefits beginning on the 151st day of your Non-Network Hospital stay.

You will have to pay your Part A Deductible unless the Non-Network Hospital stay resulted from an emergency or was immediately required due to an unforeseen Sickness injury or condition and it was not reasonable for you to obtain services from a Network Hospital.

HOW ARE MEDICARE BENEFIT PERIODS CALCULATED?

A benefit period begins on the first day you receive Inpatient Hospital Care and ends after you have been out of the Hospital and have not received care in a Skilled Nursing Facility for 60 days in a row.

WHAT COVERAGE DO I HAVE?

For Hospital Stays

When you enter the Hospital for a Medicare eligible admission, Medicare will pay for the first 60 days starting on the day you are admitted. Medicare will pay all of your eligible expenses for the first 60 days except for the Medicare Part A deductible. **You will not have to pay the Part A Deductible if your Hospital stay is in a Network Hospital. You will have to pay the Part A Deductible for your stay in**

a Non-Network Hospital unless: the admission resulted from an emergency or was immediately required due to an unforeseen Sickness, injury or condition.

If you are in the Hospital for more than 60 days, Medicare will no longer pay your covered expenses in full. From the 61st through the 90th day, Medicare covers all eligible expenses except for a certain amount which is deducted each day. The amount which is deducted each day is equal to 1/4 of the Medicare Part A deductible. The actual dollar amount is shown in your Outline of Coverage. **We pay this daily amount from the 61st day through the 90th day for you.**

Medicare will stop making payment after the 90th day unless you choose to use your Medicare reserve days. You have 60 Medicare reserve days. These are extra days available to you if you must be in the Hospital for more than 90 days. You may choose to use these days all at once or a few at a time. Once you use your reserve days, they are not renewed by Medicare.

If you choose to use your reserve days, Medicare will continue to pay all eligible expenses except for a certain amount which is deducted each day. The amount which is deducted each day is equal to 1/2 of the Medicare Part A Deductible. The actual dollar amount is shown in your Outline of Coverage. **We will pay this daily amount for you, even if you choose not to use your Medicare reserve days.**

We will pay this daily amount for you from the 91st day through the 150th day of your Hospital stay. Then we will pay 100% of the Medicare Eligible Expense beginning on the 151st day for an additional 365 days.

For Skilled Nursing Facility Confinement

To receive benefits for services in a Skilled Nursing Facility, you must have been in the Hospital for at least 3 days in a row (not counting the day of discharge) **before** you are admitted to the Skilled Nursing Facility. You also must be admitted to the Skilled Nursing Facility **within 30 days** from the day you are discharged from the Hospital.

Medicare will pay the first 20 days of your approved Skilled Nursing Facility stay in full.

Beginning on the 21st day through the 100th day, Medicare will pay all of your eligible expenses except for a certain amount which is deducted each day. This daily amount is equal to 1/8 of the Medicare Part A deductible. The actual dollar amount is shown in your Outline of Coverage. **We pay this daily amount for you.**

For Hospice Care

To receive benefits for services for Hospice Care and inpatient respite care, you must meet Medicare's requirements, including a doctor's certification of terminal illness. You can receive benefits for a stay in a Medicare-approved facility, such as a Hospice facility, Hospital or nursing home, up to 5 days each time you get respite care.

Medicare will pay all of your approved Hospice Care in full with limited Coinsurance/copayments for Outpatient drugs and inpatient respite care.

We pay the cost of the Medicare Part A Coinsurance/copayment.

For Blood

When you need blood Medicare will pay the cost of all but the first 3 pints each year. **We pay the cost of the first 3 pints, if you do not replace the blood you received**.

WHAT INPATIENT HOSPITAL SERVICES ARE COVERED?

You're covered for all inpatient Hospital services. However, you must be admitted to the Hospital on or after your Coverage Date. Also, the services must be:

- Medically Necessary;
- approved by Medicare; and
- under a Physician's direction.

Typical inpatient charges are charges for bed and board or nursing care. You're covered for these charges and for other services, such as:

- use of operating and treatment rooms;
- inpatient drugs;
- surgical dressings;
- blood processing;
- diagnostic services; and
- administration of whole blood and blood components, when there is a charge.

WHAT DO WE MEAN BY "MEDICALLY NECESSARY"?

The fact that your Physician orders a medical service does not always mean that the service is Medically Necessary or that the charge will be approved. By ''Medically Necessary'' we mean that the services:

- are required to diagnose or treat your Sickness or injury;
- meet generally accepted standards of medical practice; and
- are provided in the most cost-effective manner.

For Hospitalization to be Medically Necessary, you must need care that couldn't be given to you as an Outpatient. A Hospitalization primarily for custodial care would not qualify for benefits.

For Medicare-approved services we will never use standards more restrictive than Medicare.

WHAT IF SERVICES ARE NOT AVAILABLE FROM A NETWORK HOSPITAL?

When you must receive inpatient services that are not available from a Network Hospital, we will pay your Part A Deductible for a Medicare-approved stay in a Non-Network Hospital.

WHAT IF I NEED MEDICAL CARE IN A FOREIGN COUNTRY?

If you are in a Foreign country and receive emergency treatment during the first 60 days of your trip, we will pay 80% of the eligible charges for Medically Necessary services. If you are Hospitalized due to an emergency, we will pay 80% of the eligible charges for Medically Necessary services as long as your Hospitalization occurred during the first 60 days of your trip.

Your benefits for the services you receive in a Foreign country are subject to a **$250.00** Calendar Year deductible. You must pay this amount.

The total **lifetime maximum** that we will pay for services received in a Foreign country is **$50,000.00.**

YOUR MEDICAL/SURGICAL BENEFITS

This section of your Policy describes benefits for services provided and charged for by a properly licensed medical professional or by a Hospital when rendered on an Outpatient basis. Charges must be approved by Medicare.

The Medicare Select program does not limit your choice of medical Providers under this benefit section.

HOW MANY TIMES MAY I GET BENEFITS WHEN I SEE MY PHYSICIAN?

You're covered for all Medicare approved visits. Most visits will be office appointments. However, we also cover house calls or visits a Physician makes to your Hospital or Skilled Nursing Facility. You're also covered for Emergency Care.

Visits for routine physicals aren't covered because Medicare doesn't cover them.

WHAT DOES THIS POLICY PAY?

We pay:

- 100% of all eligible charges remaining after Medicare makes payment **-** up to the limiting charge established by law and shown on your Explanation of Medicare Benefits Form.

You pay:

- Your annual Medicare Part B Deductible ;

AM I COVERED FOR EMERGENCY CARE?

Yes, you're covered for Emergency Care if charges are approved by Medicare.

WHAT OTHER SERVICES ARE COVERED?

We pay charges for the services listed below. However, charges are covered only if they're approved by Medicare.

Surgery and Anesthesia

You're covered for surgery in or out of the Hospital. This includes surgery in a properly licensed facility specializing in Outpatient surgery.

You're covered for anesthesia administered by a medical Provider other than the operating surgeon.

Oral Surgery

Consultations

We'll pay for one second surgical opinion prior to elective surgery.

Pre-admission testing

If you're scheduled for inpatient surgery, we'll cover pre-admission testing if:

- surgery has been scheduled and your room reserved;
- testing is done by the Hospital personnel or a Physician's staff;
- the tests won't be repeated once you're admitted to the Hospital; and
- the tests would be covered by this Policy if they were done when you were an inpatient.

EEGs and EKGs

X-Rays

You're covered for x-rays ordered by a qualified professional.

Clinical and surgical pathology

Speech and physical therapy

Radiation and Chemotherapy

Diagnostic services

Outpatient renal dialysis treatments

You're covered for treatments as a Hospital Outpatient, in a licensed dialysis facility or at home.

Mental health care

You're covered for Outpatient visits for the treatment of mental illness. Treatment may be in the Physician's office or Hospital Outpatient department.

Medical equipment

You're covered for the rental or purchase of medical equipment that you need. You're also covered for internal or permanent devices, such as:

- cardiac valves,
- pacemakers,
- mandibular reconstruction devices, and
- leg, back, arm or neck braces.

Prosthetic devices

Purchase of cataract lenses and the purchase and adjustments of prosthetic devices are covered.

Ambulance service Organ transplants

Human organ and tissue transplants are covered if you're the recipient.

Remember: These services are covered only when they are approved by Medicare.

WHAT IS THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM?

The Outpatient prospective payment system consists of specific payment amounts, set by Medicare, for certain Outpatient services you receive from a Hospital, community mental health center, or other entity providing Outpatient services. Medicare has also set a specific copayment amount that must be paid for

these services. Before receiving an Outpatient service you should check with your Physician or Hospital to see if it will be paid under the Outpatient prospective payment system.

HOW ARE SERVICES PAID UNDER THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM?

We will pay the copayment amount under the Outpatient prospective payment system after you have paid the applicable deductible(s).

WHAT OTHER EXPENSES ARE NOT COVERED?

We only pay charges approved by MEDICARE. We won't pay for services and supplies that aren't specifically mentioned in this Policy. Other services we do not cover are:

— **Employment-related problems**

We don't pay for treatment of Accidental Injuries or Sickness if they're:

- related to work; or
- covered by an insurance or worker's compensation law.

This is true even if you decide not to claim benefits under the law.

— **Treatment covered or provided by Government Programs**

The only exception is for medical assistance under Article V, VI, or VII of the Illinois Public Aid Code.

— **Treatment for war-related injuries and Sickness**

This limitation applies to injuries and Sicknesses caused by war or acts of war, whether declared or undeclared.

— **Treatment provided by employers or unions**

This limitation applies to treatment received from medical and dental departments maintained by or for:

- an employer;
- a mutual benefit association;
- a labor union;
- a trustee; or
- a similar entity.

— **Free treatment**

We don't pay for free treatment, or treatment that would have been free if you were not insured under this Policy.

— **Custodial Care**

Custodial care means services which do not require technical skills or professional training. Assistance with activities of daily living (bathing, feeding, meal preparation) that is not a part of an approved at-home recovery benefit is an example of custodial care.

— **Services you no longer need**

— **Routine physical examinations**

— **Cosmetic surgery**

The only exception is for oral surgery.

— **Foot care**

We don't pay for routine foot care or the treatment of flat feet or subluxations of the foot.

— **Miscellaneous fees**

We don’t pay for fees charged to complete a claim form or because you didn’t keep a scheduled appointment.

— **Services from family members**

We don’t pay for services performed by a member of your immediate family.

— **Outpatient prescription drugs**

— **Private duty nursing services**

— **At-home recovery services**

— **Preventive medical care**

MEDICARE SUPPLEMENT PREMIUMS

WHEN ARE MEDICARE SUPPLEMENT PREMIUMS DUE?

Your first Medicare Supplement Premium is due on the Effective Date of this Policy. Later Medicare Supplement Premiums are due on the first day of the Medicare Supplement Premium period. Medicare Supplement Premium periods and due dates are shown on your bill.

IN CASE OF DEATH

We'll refund unearned Medicare Supplement Premiums to your estate or authorized individual. A representative of your estate or authorized individual must send us a written request or call.

WHAT IF I'M LATE PAYING MY MEDICARE SUPPLEMENT PREMIUM?

After you have paid your first Medicare Supplement Premium you have a 31-day grace period after the due date to pay your future Medicare Supplement Premiums. You must pay before the grace period ends. If you don't, we won't pay benefits during those 31 days. We'll also cancel your Policy at the end of the grace period.

HOW ARE MY MEDICARE SUPPLEMENT PREMIUMS DETERMINED?

Your Medicare Supplement Premium may depend on your age, gender, Tobacco User Status and/or geographical location.

We may raise your Medicare Supplement Premiums if we increase your benefits under this Policy or your age category changes. When completing the application, you may need to make a gender selection. Additionally, if you meet the definition of a Tobacco User, you may pay a higher Medicare Supplement Premium for your health coverage. We may be required by law to add to your benefits, or we may increase them for another reason. We may also raise your Medicare Supplement Premium on any Policy anniversary or Medicare Supplement Premium due date.

If we raise Medicare Supplement Premiums for any reason, we'll give you 30 days prior written notice. We'll send any notice to you using the address on your application. Please notify us in writing or call 1-800-624-1723 if you change your address.

Premium Discounts

A BCBSIL Medicare Supplement premium discount may be available. Eligibility criteria are described below. If you are eligible for a discount, the discount will be applied to your next bill and remain in effect as long as you are enrolled in your BCBSIL Medicare Supplement plan. Discounts cannot be combined; only one type of discount per member is permitted.

Household Discount

You may be eligible for a discount if you reside with a spouse or civil union/domestic partner or have resided with as many as three adults age 60 or older for the last 12 months. Applies to BCBSIL Medicare Supplement policies issued with an effective date on or after May 1, 2019. The discount is 10%.

Continue with Blue℠ Discount

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2022 and you were enrolled in a Blue Cross and Blue Shield commercial group or individual health insurance coverage plan and that coverage was within one year of your BCBSIL Medicare Supplement policy becoming effective. The discount is 7%.

Blue Family Discount℠

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2024 and you meet the criteria for both the Household Discount AND the Continue with Blue Discount. The discount is 12%.

ADDITIONAL POLICY INFORMATION

HOW DO I USE MY ID CARD?

Present it when you receive medical services. Your ID Card shows your Policy number and the Effective Date of your Policy.

Do not lend your ID Card to anyone. If someone uses your ID Card, any payments we make may be credited against your benefits. We may, but are not required to, try to get the payment back.

CAN I CHOOSE MY PHYSICIAN AND HOSPITAL?

Yes. You select your Physician and all other medical Providers.

We aren't evaluating the quality or skill of a medical Provider when we report that the Provider:

- is or isn't approved by Medicare;
- is or isn't qualified by Medicare; or
- participates or doesn't participate in Medicare.

We will not furnish any medical service. We're not responsible if any Physician or other medical Provider refuses to serve you. We're also not responsible for any of their actions.

HOW DO I FILE CLAIMS?

Be sure to use your ID Card when you receive Hospital and medical services. This will speed up claims processing. Your Hospital and related Physician service claims will be sent to Medicare for you. Medicare will send your claims to Blue Cross and Blue Shield of Illinois for additional processing.

If you receive services from a Provider that does not accept Medicare Assignment and the Provider will not file claims on your behalf, you can obtain a Medicare claim form by visiting www.Medicare.gov, or by contacting Medicare Customer Service, or from any Social Security office. The claim must be submitted to Medicare first. Once Medicare has processed, you will receive a Medicare Explanation of Benefits that will tell you what Medicare has paid. Send us a copy of the Medicare Explanation of Benefits within 60 days of receipt.

Be sure to print your Blue Cross and Blue Shield of Illinois ID number at the top. You'll find the number on your ID Card.

Please send it to:

Blue Cross and Blue Shield of Illinois
P. O. Box 2620
Chicago, IL 60690-2620

WHAT IF I CAN'T FILE MY CLAIM IN TIME?

File as soon as you can. We'll still process your claim up to 12 months or one Calendar Year, after the date of service, if you show us that:

- it wasn't reasonably possible to file earlier; and
- you filed as soon as you reasonably could.

WHO RECEIVES CLAIM PAYMENTS?

We'll usually pay your medical Provider if payment is due. Otherwise, we'll pay you.

We are not obligated to honor any request you make that we withhold payment from your medical Provider for covered expenses. We won't be liable to you if we pay your expenses to your Provider after you ask us not to.

IN CASE OF DEATH

In case of your death, benefits owed to you, will be paid to your estate or authorized individual.

WHAT IF MY CLAIM IS DENIED?

You can call or write and request a review or verbal approval if we deny all or part of your claim. Write to:

Claim Review Section
Blue Cross and Blue Shield of Illinois
P.O. Box 2401
Chicago, Illinois 60690; or
call 1-800-624-1723

Be sure to write or call within 60 days of denial. Within 30 days of asking for a review, you may send more information or comments.

You may also review our records. However, you must make an appointment in writing to do so. You may have someone represent you. We must have your representative's name in writing. Within 60 days of your review request, we'll:

- send you our decision on the claim; or
- notify you that we'll need another 60 days.

A review may not take more than 120 days, even if you request it.

GRIEVANCE PROCEDURES

You have a right to submit a Grievance to us if you are dissatisfied with any aspect of processing your coverage. Write to us at the following address within 60 days of the date you are notified of any adverse action:

Grievance Committee
Blue Cross and Blue Shield of Illinois
Medicare Select Program
Direct Markets
P. O. Box 1637
Chicago, Illinois 60690-1637

Your Grievance will be reviewed by a committee comprised of Blue Cross and Blue Shield of Illinois technical and management personnel who have authority to take corrective action, if warranted.

Unless additional information from an outside source is required to complete our review, we'll send you a response within 30 days of receipt of your Grievance.

If we determine that additional information from an outside source is required to complete our review, we'll notify you within 30 days of this determination. An additional 30 days may be required to finalize, research and respond to your Grievance. In any case, a response will be sent to you within 60 days of receipt of your Grievance.

DEPARTMENT OF INSURANCE ADDRESSES

You may discuss your claim with the Illinois Department of Insurance. The addresses of the Department's Consumer Divisions are:

Illinois Department of Insurance
122 South Michigan Ave, 19th Floor
Chicago, Illinois 60603

or

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

CAN I ASSIGN MY COVERAGE?

No. Rights under this Policy aren't assignable. That means you can't give your rights to someone else. You'll lose your coverage if you allow someone else to claim benefits under your Policy.

DO YOU EXCHANGE MEDICAL INFORMATION ABOUT ME?

Yes. We may exchange medical information with:

- anyone who provides medical services and supplies to you;
- other Blue Cross or Blue Shield plans;
- other insurance companies;

- employee benefit associations;
- governmental bodies or programs; or
- any other person or group (only for the purpose of processing and paying claims).

We may only ask about or give information on:

- a problem for which you're claiming benefits;
- your medical history, if relevant; or
- any benefits you've received.

WHAT ABOUT MISSTATEMENTS ON MY APPLICATION?

If a misstatement on your application affects your coverage, we'll use the correct fact to decide your benefits.

Medicare Supplement Premiums are based on your correct age, gender, status and/or geographical location. If you've misstated your age, Tobacco User status and/or geographic location and the correct Medicare Supplement Premium is more than you've been paying, you'll have to pay us the amount due from the date your coverage began.

WHAT LIMITS ARE THERE ON LEGAL ACTION?

If we deny a claim, you may choose to sue us for benefits. However, you can't sue until 60 days after a claim denial. You must sue within three years of a claim denial. If we extend the time allowed for filing a claim, that extension won't affect these limits.

MAY I VOTE AT THE ANNUAL MEETING?

Yes. Our annual meetings are scheduled to be held at 12:30 p.m. on the last Tuesday in October. They're held at our main office:

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

You may vote in person or by proxy (a person you have selected to represent you).

ADDITIONAL BENEFITS

As part of your Blue Cross and Blue Shield of Illinois Medicare Supplement Plus policy the Policy Holder will have access to the following benefits each Calendar Year through a contracted network of providers. These services are not covered under Original Medicare.

VISION CARE

Coverage for the vision care services is outlined below. All other provisions in your Medicare Supplement Plus policy apply to this Vision Care Benefit unless specifically indicated otherwise below.

The Policy Holder will have access to one routine eye exam and $130 materials allowance each calendar year through a contracted network of providers.

Schedule of Vision Coverage

Vision Care Services		
	In-Network	Out-of-Network
Routine eye examination with dilation (when professionally indicated) One per every 12 months	$0	$40
Eyeglasses OR contact lenses (conventional or disposable) 12 Months	Remaining amount after $130 reimbursement	Remaining amount after $65 reimbursement

A routine eye exam includes:

1. Examination of orbits;
2. Test vision acuity;
3. Gross visual testing by confrontation or other means;
4. Ocular motility;
5. Examination of pupils
6. Measurement of intraocular pressure; and
7. Ophthalmoscopic examination with pupillary dilation*, as indicated, of the following:
    a. Optic disc(s) and posterior segment;
    b. Macula;
    c. Retinal periphery;
    d. Retinal vessels; and
    e. Vitreous.

* Pupillary dilations required for members with diabetes.

* In some cases, exam may be completed with other instrumentation because of Policy Holder limitations.

For a list of the contracted network of providers visit our website at https://eyedoclocator.eyemedvisioncare.com/member/en

DENTAL CARE

Coverage for the dental care services is outlined below. All other provisions in your Medicare Supplement Plus policy apply to this dental care benefit unless specifically indicated otherwise below.

DENTAL CARE DEFINITIONS

Throughout this Dental Care section, many words are used which have a specific meaning when applied to your dental care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Dental Care section, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your Dental Care benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER

DENTAL BENEFIT PERIOD.....means the period of time during which you receive Covered Services for which the Plan will provide Benefits. The Dental Benefit Period is a period of one year which begins on January 1st of each year. When you first enroll under this dental coverage, your first Dental Benefit Period begins on your Effective date and ends on December 31st of the same year.

DENTAL BENEFIT WAITING PERIOD.....means the number of months that you must be continuously covered under this benefit program before you are eligible to receive Benefits for certain dental Covered Services.

DENTAL CLAIM.....means notification in a form acceptable to Blue Cross and Blue Shield of Illinois 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 Dental Claim Charge, and any other information which Blue Cross and Blue Shield of Illinois may request in connection with services rendered to you.

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

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

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

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

COVERED SERVICE.....means a service or supply specified in this Policy for which Benefits will be provided.

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

DENTIST.....means a duly licensed dentist, operating within the scope of his/her license.

- A "Participating Dentist" means a Dentist who has a written agreement with Blue Cross and Blue Shield of Illinois or the entity chosen by Blue Cross and Blue Shield of Illinois to administer a Participating Provider Option Dental program to provide services to you at the time you receive the services.
- A "Non-Participating Dentist" means a Dentist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or the entity chosen by Blue Cross and Blue Shield of Illinois to

administer a Participating Provider Option Dental program to provide services to participants in the Participating Provider Option program.

ELIGIBLE PERSON.....means a person who meets the eligibility requirements for this dental coverage, as described in the COVERAGE AND PREMIUM INFORMATION section of this Policy.

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

MAXIMUM ALLOWANCE.....means the amount determined by Blue Cross and Blue Shield of Illinois, 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 Participating Dentists, and Non-Participating Providers will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by Blue Cross and Blue Shield of Illinois.

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 by itself make such procedure Medically Necessary.

PARTICIPATING PROVIDER OPTION.....means a program of dental care Benefits designed to provide you with economic incentives for using designated Providers of dental care services.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches and operating within the scope of his/her license.

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

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

- A “Plan Provider” means a Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.
- A “Non-Plan Provider” means a Provider that does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

SCHEDULE OF DENTAL COVERAGE

Covered Services	**In-Network** Policy Holder pays...	**Out-of-Network** Policy Holder pays...
Diagnostic Services • Periodic oral evaluations • Problem focused oral evaluations • Comprehensive oral evaluations • 2 times per year	$0	50% of the Providers Charge
Preventive Services • Prophylaxis (cleanings) • 2 times per year	$0	50% of the Providers Charge
Diagnostic Radiographs • Full-mouth and panoramic films • Bitewing films • Periapical films • 1 Per Year	$0	50% of the Providers Charge
Basic Restorative Dental Services • Amalgams • Resin-based composite restorations • 1 per tooth per calendar year	50% of the Providers Charge	50% of the Providers Charge
Non-Surgical Extractions • Removal of retained coronal remnants • Removal of erupted tooth or exposed root • Unlimited	25% of the Providers Charge	50% of the Providers Charge
	Participating Dentist	**Non-Participating Dentist***
Deductible	$0	$0

*All Benefits are based upon the Maximum Allowance, which is the amount determined by Blue Cross and Blue Shield of Illinois as the maximum amount for payment of Benefits. A Participating Dentist cannot balance bill for charges in excess of the Maximum Allowance. Benefits for services provided by a Non-Participating Dentist will be based upon the same Maximum Allowance, and it is likely that the Non-Participating Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses.

YOUR PARTICIPATING PROVIDER NETWORK

Your Medicare Supplement Plus policy contains special provisions (Benefit reductions) which apply whenever you use Dentists who are not members of the Participating Provider Network. If you use a Non-Participating Dentist, you will be responsible for the following:

- Charges for any services which are not covered under your Policy
- Any Deductible or Coinsurance amounts which are applicable to your coverage (*including the higher Deductible and/or Coinsurance amounts which apply to Non-Participating Provider services*)
- The difference, if any, between your Dentist's "billed charges" and the Plan's Maximum Allowance Charge for the Covered Services

The Benefits provided by the Plan and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating Dentist or Non-Participating Dentist.

Participating Dentists will accept the Maximum Allowance as payment in full. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Maximum Allowance. Therefore, you are responsible for the difference between the Plan's Benefit and the Dentist's charge to you, in addition to any Coinsurance and/or Deductible amounts applicable to your services.

Non-Participating Dentists are Dentists who have not signed an agreement to accept the Maximum Allowance as the Benefit in full. Therefore, you are responsible for the difference between the Plan's Non-Participating Benefit and the Dentist's billed charge to you, in addition to any Deductible and/or Coinsurance amounts applicable to your services.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Dentist or the Plan.

HOW YOUR DENTAL COVERAGE WORKS

Dental Coverage

You have chosen a Blue Cross and Blue Shield of Illinois Medicare Supplement Plus policy for the administration of your dental Benefits. The Participating Provider Option is a program of dental care Benefits designed to provide you with economic incentives for using designated Providers of dental care services.

As a participant in the Participating Provider Option program directory of Participating Dentists is available to you. You can visit the Blue Cross and Blue Shield of Illinois website at *www.bcbsil.com* for a list of Participating Dentists or you can request a copy of the directory and one will be sent to you upon request by contacting the number on the back of your identification card. While there may be changes in the directory from time to time, selection of Participating Dentists by Blue Cross and Blue Shield of Illinois will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Dentist before undergoing treatment to make certain of his/her participation status. Although you can go to the Dentist of your choice, Benefits under the Participating Provider Option will be greater when you use the services of a Participating Dentist.

The Benefits of this section are subject to all of the terms and conditions of this Policy. Certain Benefits may also be subject to a Dental Benefit Waiting Period. Please refer to the DEFINITIONS and EXCLUSIONS AND LIMITATIONS sections of this DENTAL CARE section for additional information regarding any limitations and/or special conditions pertaining to your Benefits.

For Benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by Blue Cross and Blue Shield of Illinois until after receipt of an Attending Dentist's Statement. In addition, Benefits will be provided only if services are rendered on or after your Coverage Date.

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Dental Benefit Period

Your Dental Benefit Period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first Dental Benefit Period begins on your Coverage Date and ends on the first December 31st following that date.

Coinsurance Requirements

Your Coinsurance is the percentage of the Maximum Allowance that you are required to pay for Covered Services after the Deductible, if applicable, has been met. For each Covered Service, and after you have met the Deductible, if applicable, this Policy covers a certain percentage (specified on the **Outline of Coverage**) of the Maximum Allowance for the Covered Service. When a Covered Service is received

from a Participating Provider, you pay only the Deductible and/or Coinsurance amount applicable to that service. When a Covered Service is received from a Non-Participating Provider that exceeds the Maximum Allowance and/or Usual & Customary Fee charged for the Covered Service.

Benefit Payment for Dental Services

The Benefits provided by Blue Cross and Blue Shield of Illinois and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non- Participating Dentist. Your Coinsurance amounts are shown on the **Outline of Coverage**.

Participating Dentists are Dentists who have signed an agreement with Blue Cross and Blue Shield of Illinois or the entity chosen by Blue Cross and Blue Shield of Illinois to administer a Participating Provider Option Dental program, to accept the Maximum Allowance as payment in full. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield of Illinois benefit payment and the Maximum Allowance for the particular Covered Service— that is, your Coinsurance amounts and Deductible.

Non-Participating Dentists are Dentists who have not signed an agreement with Blue Cross and Blue Shield of Illinois or the entity chosen by Blue Cross and Blue Shield of Illinois to administer a Participating Provider Option Dental program, to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Dentists for the difference between the Blue Cross and Blue Shield of Illinois benefit payment and such Dentist's charge to you. Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Dentist or Blue Cross and Blue Shield of Illinois.

Benefit Maximum

The maximum amount available for you in dental Benefits each Dental Benefit Period is shown on your **Outline of Coverage**. This is an individual maximum. This maximum applies to all of your Dental Covered Services except for Orthodontic Dental Services. Orthodontic Dental Services are subject to a separate lifetime maximum shown on your **Outline of Coverage**. Any expenses incurred beyond the benefit maximum are your responsibility.

DENTAL BENEFIT SECTION

Covered Services

The Benefits of this section are subject to all the terms and conditions of your Policy. Benefits are available only for services and supplies that are determined to be "Medically Necessary", unless otherwise specified. All Covered Services listed in this section are subject to the *Exclusions and Limitations* section of this Policy, which lists services, supplies, situations or related expenses that are not covered.

It is important for you to refer to your *Outline of Coverage* to find out what your Deductible, Dental Benefit Period Maximums, Coinsurance and Out-of-Pocket Maximums will be for a Covered Service. If you do not have a *Outline of Coverage*, please call a Customer Service Representative at the number shown on your identification card.

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist, a dental auxiliary, or a Physician. When the term "Dentist" is used in this Policy, it will mean Dentist or Physician.

DIAGNOSTIC EVALUATIONS

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

- Periodic oral evaluations.
- Problem focused oral evaluations, whether limited, detailed or extensive.
- Comprehensive oral evaluations for new or established patients.

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to one comprehensive and one periodic examinations every Dental benefit period

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 SERVICES

Preventive services are performed to prevent dental disease. Covered Services include:

- Prophylaxis—Professional cleaning, scaling and polishing of the teeth. Benefits will be limited to two cleanings every 12 months.

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

DIAGNOSTIC RADIOGRAPHS

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

- Full-mouth (intraoral complete series) and panoramic films—Benefits are limited to a combined maximum of once every 12 months.
- Bitewing films—Benefits are limited to four horizontal films or eight vertical films once every 12 months. However, Benefits are not available for bitewing films taken on the same date as full-mouth films or within 6 months of a complete series of radiographic images.
- Periapical films, as necessary for diagnosis—Benefits are limited to one every 12 months. Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

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:

- Amalgams restorations—Benefits are limited to one restoration per tooth every 12 months.
- Resin-based composite restorations—Benefits are limited to one restoration per tooth every 12 months.
- Sedative Filings

Benefits will not be provided for restorations placed within 12 months of the initial placement by the same Dentist.

NON-SURGICALEXTRACTIONS

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

- Removal of retained coronal remnants—deciduous tooth.
- Removal of erupted tooth or exposed root.

EXCLUSIONS AND LIMITATIONS

These general *Exclusions and Limitations* apply to all services described in this dental Policy. 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 dental Policy.

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, this Policy 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 by itself make such a procedure 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 service or Course of Treatment to treat your dental condition, the Benefit will be based on the less costly Covered Service or Course of Treatment.
- The alternate benefit Copayment or Coinsurance will be based on the less costly Covered Service and you will be responsible to pay the difference between the less costly service and more costly service elected.
- If you and your Dentist or Physician decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the benefit for the standard procedures for dental services

— Non-Compliance with Prescribed Care

— Any additional treatment and resulting liability which is caused by the lack of an Eligible Person's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Eligible Person.

EXCLUSIONS—WHAT IS NOT COVERED

No Dental Benefits will be provided under this Policy for:

1. Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
2. Amounts which are in excess of the Maximum Allowance.
3. 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 included in the MEDICALLY NECESSARY ORTHODONTIC DENTAL SERVICES subsection of the DENTAL BENEFIT SECTION.
4. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders or to increase vertical dimension.
5. Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury, except for persons under the age of 19.

6. Services and supplies for any illness or injury suffered after the Eligible Person's Coverage Date as a result of war or any war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
7. Services or supplies that do not meet accepted standards of dental practice.
8. Experimental, Investigational and/or unproven services and supplies and all related services and supplies.
9. Hospital and ancillary charges.
10. Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of injuries.
11. 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.
12. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
13. Services rendered by a Dentist related to you by blood or marriage.
14. 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.
15. Dental Claims for a service which is for the same service performed on the same date for the same member.
16. Services or supplies received for behavior management or consultation purposes.
17. Any services or supplies to the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental agencies provide benefits (some state or federal laws may affect how we apply this exclusion).
18. 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.
19. Charges for nutritional, tobacco or oral hygiene counseling.
20. Charges for local, state or territorial taxes on dental services or procedures.
21. Charges for the administration of infection control procedures as required by local, state or federal mandates.
22. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
23. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a Dental Claim form or forwarding requested records or x-rays.
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 a tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.

26. Charges for partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your Coverage Date under this Policy; 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. Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
28. Case presentations or detailed and extensive treatment planning when billed for separately.
29. Charges for occlusion analysis, diagnostic casts, or occlusal adjustments.
30. Gold foil restorations.
31. Cone beam imaging and cone beam MRI procedures.
32. Sealants for teeth other than permanent molars.
33. Orthodontic care for dependent children age 19 and over.
34. Localized delivery of antimicrobial agents or chemotherapeutic agents.
35. Bone grafts in conjunction with extractions, apicoectomy or any non- covered service or non-covered implants.
36. Anatomical crown exposures.
37. The replacement of lost, missing or stolen appliances and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
38. Dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.
39. Restoration occlusion on incisal edges due to bruxism or harmful habits.
40. Treatment to replace teeth which were missing prior to the Coverage Date.
41. Congenitally missing teeth.
42. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
43. 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.
44. Tests and oral pathology procedures, or for re-evaluations.
45. Radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.
46. Restorations placed within 12 months of the initial placement by the same Dentist.
47. Local anesthesia or other drugs or medicaments and/or their application.
48. Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
49. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of performed dowel and post, or post removal.
50. Endodontic therapy if you discontinue endodontic treatment.
51. Surgical services related to a congenital malformation.
52. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
53. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

54. 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.
55. Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
56. 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 this Policy. You must provide the Plan with all documents it needs to enforce its rights under this provision.

HOW TO FILE A CLAIM

FILING DENTAL CLAIMS

In order to obtain your dental Benefits under this Policy, it is necessary for a Dental Claim to be filed with Blue Cross and Blue Shield of Illinois.

To file a Dental Claim, usually all you will have to do it show your identification card to your Dentist. They will file your Dental Claim for you. Remember, however, it is your responsibility to ensure that the necessary Dental Claim information has been provided to Blue Cross and Blue Shield of Illinois.

In certain situations, you will have to file your own Dental Claim. These Dental Claim forms are available from Blue Cross and Blue Shield of Illinois. You must complete and sign the Policy Holder/Insured Information of the Attending Dentist's Statement.

As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement, and file it with:

Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

Dental Claims must be filed with Blue Cross and Blue Shield within 365 days from the date your Covered Service was rendered. Dental Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing Dental Claims call Blue Cross and Blue Shield of Illinois.

DENTAL CLAIM PROCEDURES

Blue Cross and Blue Shield of Illinois will usually process all Dental Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Dental Claim. In the event that Blue Cross and Blue Shield of Illinois does not process a Dental 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 Dental Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. Blue Cross and Blue Shield of Illinois will notify you or the valid assignee when all information required to pay a Dental Claim within 30 days of the Dental Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Dental Claims and Assignment of Benefits" provision in the GENERAL PROVISIONS section of this Policy.)

If the Dental Claim is denied, you will receive a notice from Blue Cross and Blue Shield of Illinois with: (1) the reasons for denial; (2) a reference to the dental care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the Dental Claim, and (4) an explanation of how you may have the Dental Claim reviewed by Blue Cross and Blue Shield of Illinois if you do not agree with the denial.

DENTAL CLAIM REVIEW PROCEDURES

If your Dental Claim has been denied, you may request an appeal of your Dental Claim. Blue Cross and Blue Shield of Illinois will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield of Illinois will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

You may also designate a representative to act for you in the appeal procedure. 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 authorized representative may call Blue Cross and Blue Shield of Illinois at the number on the back of your, identification card.

While Blue Cross and Blue Shield of Illinois will honor telephone requests for information, such inquiries will not constitute a request for an appeal.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial or at any time during the Dental Claim appeal process. Blue Cross and Blue Shield of Illinois will give you a written decision within 60 days after it receives your request for appeal.

If you have any questions about the Dental Claims procedures or the appeal procedure, write or call Blue Cross and Blue Shield of Illinois Headquarters. Blue Cross and Blue Shield of Illinois offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

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

Filing an appeal does not prevent you from filing a complaint with the Illinois Department of Insurance or keep Illinois Department of Insurance from investigating a complaint. Illinois Department of Insurance can be contacted at the following addresses:

Illinois Department of Insurance Consumer Division
320 West Washington Street
Springfield, Illinois 62767
Toll Free: 866-445-5364
TDD: 866-323-5321
Phone: 217-782-4515
Fax: 217-782-5020

122 S. Michigan Avenue,
19th Floor
Chicago, IL 60603
Phone: 312-814-2420
Fax: 312-814-5416

If you have a Dental Claim for benefits which is denied or ignored, you may have the right to file suit in a state or federal court.

ADDITIONAL BENEFIT DISCOUNTS

As part of your Blue Cross and Blue Shield of Illinois Medicare Supplement Plus policy the Policy Holder will have access to additional benefit discounts each Calendar Year.

- Hearing Care
    - The Policy Holder will have access to one routine hearing examination per calendar year at no cost, and discounts on hearing aids.
- Silver Sneakers
    - The Policy Holder will have access to Tivity Health Silver Sneakers which provides discounted access to gym memberships and fitness programs.

BlueCross BlueShield of Illinois

Underwritten by HCSC Insurance Services Company

IL-GSP-HISC-2024