Your Health Care Benefit Program

BlueChoice® Select 80/50

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

GROUP CERTIFICATE RIDER

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

This Rider is attached to and becomes a part of your Certificate. The Certificate and any Riders thereto are amended as stated below.

A. EFFECTIVE DATE

For Certificates in effect on or after September 23, 2010, this Rider is effective on the Group effective date.

B. DEPENDENT COVERAGE

Benefits will be provided under this health Certificate for your and/or your spouse's enrolled child(ren) under the age of 26.

Child(ren), used hereafter, means natural child(ren), stepchild(ren), adopted child(ren) (including a child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care), child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child(ren)'s financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. If the covered child(ren) is eligible military personnel, the limiting age is 30 years of age as described under the **FAMILY COVERAGE** provision in the ELIGIBILITY SECTION of this Certificate.

C. PREEXISTING CONDITIONS WAITING PERIOD

The Preexisting Conditions waiting period will not apply to you and/or your enrolled family member(s) who are under age 19.

D. INTERNAL AND EXTERNAL REVIEW INFORMATION AND PROCEDURES

The following provisions are added to your Certificate:

INQUIRIES AND COMPLAINTS

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

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

Blue Cross and Blue Shield has a team of professionals available to assist you with inquiries and complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of Care

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
P.O. Box 2401
Chicago, IL 60690-1364

When you contact Customer Service, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your case within 30 days of receipt by Customer Service. If Blue Cross and Blue Shield needs more information, you will be contacted. If a decision will be delayed due to the need for additional information, you will be contacted.

APPEALS

If you submit an inquiry or complaint and it is not resolved to your satisfaction, you may appeal the decision.

An appeal is an oral or written request for a review of an adverse decision or action by Blue Cross and Blue Shield or its employees. An appeal may be filed by you, a person designated to act on your behalf, or any health care provider.

No person reviewing the appeal may have been involved in the initial determination that is the subject of the appeal.

If an appeal is not resolved to your satisfaction, you may appeal Blue Cross and Blue Shield's decision to Illinois Department of Insurance. Illinois Department of Insurance will notify Blue Cross and Blue Shield of the appeal. Blue Cross and Blue Shield will have 21 days to respond to the Illinois Department of Insurance.

URGENT/EXPEDITED CLINICAL APPEALS

An urgent/expedited clinical appeal is an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatment ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your health.

Upon receipt of an urgent/expedited pre-service or concurrent clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. Blue Cross and Blue Shield shall render a determination on the appeal within 24 hours after it receives the requested information.

CLINICAL APPEALS

A clinical appeal is an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that does not meet the definition of an urgent/expedited clinical appeal.

Upon receipt of a non-urgent pre-service or post-service clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of the request. Blue Cross and Blue Shield shall render a determination on the appeal within 15 business days after it receives the requested information but in no event more than 30 days after the appeal has been received by Blue Cross and Blue Shield.

NOTIFICATION

Blue Cross and Blue Shield will notify the party filing the appeal, you, and any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notification will include:

- A clear and detailed reason for the determination.
- Medical or clinical criteria used in the determination.
- Procedures for requesting an external independent review, if your appeal is denied.

INDEPENDENT EXTERNAL REVIEW

An **"Adverse Determination"** means a determination by Blue Cross and Blue Shield or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated.

A **"Final Adverse Determination"** means an adverse determination involving a covered benefit that has been upheld by Blue Cross and Blue Shield or its designated utilization review organization, at the completion of Blue Cross and Blue Shield's internal grievance process procedures as set forth by the Managed Care Reform and Patient Rights Act.

EXPEDITED INDEPENDENT EXTERNAL REVIEW

If you have a medical condition where the timeframe for completion of a) an expedited internal review of a grievance involving an Adverse Determination; b) a Final Adverse Determination as set forth in the Managed Care Reform and Patient Rights Act; or, c) a standard external review as set forth in the Managed Care Reform and Patient Rights Act, would seriously jeopardize your life or health or your ability to regain maximum function, then you have the right to have the Adverse Determination or Final Adverse Determination reviewed by an independent review organization not associated

with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you may request an expedited independent external review.

You may also request an expedited external review if the treatment or service in question has been denied on the basis that it 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.

Your request for an expedited independent external review may be submitted orally or in writing. Upon receipt of your request, an independent review organization registered with the Illinois Department of Insurance will be assigned to review Blue Cross and Blue Shield's decision.

Within two business days after the date of receipt of all necessary information, the expedited independent external reviewer will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and you will receive notification from Blue Cross and Blue Shield. The decision of the external independent reviewer is final. Until July 1, 2013, if you disagree with the determination of the external independent reviewer, you may contact the Illinois Department of Insurance.

STANDARD EXTERNAL INDEPENDENT REVIEW

You must submit a written request for an external independent review within four months of receiving an Adverse Determination or Final Adverse Determination of a clinical appeal. You may submit additional information or documentation to support your request for the health care services.

Within five business days of receipt of your request, Blue Cross and Blue Shield will complete a preliminary review to determine whether:

- you or your dependent was a covered person at the time health care services were requested or provided;
- the service that is the subject of the Adverse Determination or the Final Adverse Determination was a Covered Service under this Certificate but Blue Cross and Blue Shield has determined that the health care service does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness
- you have exhausted Blue Cross and Blue Shield's internal grievance process; and
- you have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the

subject of the Adverse Determination or Final Adverse Determination is a Covered Service under this Certificate, except for Blue Cross and Blue Shield's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under this Certificate. In addition, the licensed Physician who ordered or provided the services in question has certified that one of the following situations is applicable:

- standard health care services or treatments have not been effective in improving your condition;
- standard health care services or treatments are not medically appropriate;
- there is no available standard health care services or treatment covered by Blue Cross and Blue Shield that is more beneficial than the recommended or requested service or treatment;
- 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
- 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.

Within one business day after completion of the preliminary review, Blue Cross and Blue Shield shall notify you or your designated representative in writing whether the request is complete and is eligible for an external review. If the request is not complete or not eligible for an external review, you shall be notified by Blue Cross and Blue Shield in writing of what materials are required or the reason for ineligibility.

Within five business days of determining that a request is eligible for an external review, Blue Cross and Blue Shield shall a) assign an independent review organization from the list of approved independent review organizations; and b) notify you or your designated representative of the request's eligibility and acceptance for an external review and the name of the independent review organization.

Within five business days upon the assignment of an external independent review organization, Blue Cross and Blue Shield or its designated utilization review organization, shall provide to the external independent reviewer the documents and any information considered in making the Adverse Determination or Final Adverse Determination.

Within five business days after the date of receipt of the necessary information, the external independent reviewer will render a decision based on whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and you will receive notification from Blue Cross and Blue Shield. The decision of the external independent reviewer is final. Un-

til July 1, 2013, if you disagree with the determination of the external independent reviewer, you may appeal the decision of the external independent review organization to the Illinois Department of Insurance at 1-877-527-9431.

Benefits will not be provided for services or supplies not covered under your Certificate even if the external independent reviewer determines that the health care services being appealed were medically appropriate.

NON-CLINICAL APPEALS

A non-clinical appeal is an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

Upon receipt of a pre-service or post-service non-clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of the request. Blue Cross and Blue Shield shall render a decision on the appeal within 15 business days after it receives the requested information.

NOTIFICATION

Blue Cross and Blue Shield will notify you and the party filing the non-clinical appeal orally of its determination, followed-up by a written notice of determination.

The written notification will include:

- A clear and detailed reason for the determination.
- Contractual, administrative or protocol for the determination.

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
100 West Randolph Street
Suite 15-100
Chicago, IL 60601

or

Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767

In addition, if you have an adverse appeal determination, you may file civil action in a state or federal court.

E. GRANDFATHERED HEALTH PLAN DISCLOSURE

This group health plan believes this coverage is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage

that was already in effect when that law was enacted. Being a grandfathered health plan means that the policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits for any individual.

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

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

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

Attest:

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

Karen Atwood
President

A message from

BLUE CROSS AND BLUE SHIELD

Your Group has entered into an agreement with us (Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois) to provide you with this benefit program. Like most people, you probably have many questions about your coverage. This Certificate contains a great deal of information about the services and supplies for which benefits will be provided under your benefit program. Please read your entire Certificate very carefully. We hope that most of the questions you have about your coverage will be answered.

In this Certificate we refer to our company as "Blue Cross and Blue Shield" and we refer to the company that you work for 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.

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

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

Sincerely,

Maurice Smith
President

NOTICE

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

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

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

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Section §562.3 of the Illinois Insurance Code. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

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BENEFIT HIGHLIGHTS

Your benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire Certificate.

THE MEDICAL SERVICES ADVISORY PROGRAM MSA®′ Registered Mark of Health Care Service Corporation a Mutual Legal Reserve Company	A special program designed to assist you in determining the course of treatment that will maximize your benefits under this Certificate
Lifetime Maximum for all Benefits	Unlimited
Individual Deductible	
— In-Network	$500 per benefit period
— Out-of-Network and Non-Plan Provider	$2,000 per benefit period
Family Deductible	3 individual deductibles
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	
— In-Network	$2,000 per benefit period
— Out-of-Network	$8,000 per benefit period
— Non-Plan Provider	No limit
Family Out-of-Pocket Expense Limit	3 individual out-of-pocket expense limits
Chiropractic and Osteopathic Manipulation Benefit Maximum	30 visits per benefit period
Naprapathic Services Benefit Maximum	15 visits per benefit period
HOSPITAL BENEFITS	
Payment level for Covered Services received **In-Network:**	
— Inpatient Covered Services	80% of the Eligible Charge
— Outpatient Covered Services	80% of the Eligible Charge
Payment level for Covered Services received **Out-of-Network:**	
— Inpatient Deductible	$300 per admission
— Inpatient Covered Services	50% of the Eligible Charge

— Outpatient Covered Services	50% of the Eligible Charge
Payment level for Covered Services from a **Non-Plan Provider**	50% of the Eligible Charge
Hospital Emergency Care	
— Payment level for Emergency Accident Care received either In-Network, Out-of-Network or from a Non-Plan Provider	80% of the Eligible Charge, no deductible
— Payment level for Emergency Medical Care received either In-Network, Out-of-Network or from a Non-Plan Provider	80% of the Eligible Charge, no deductible
Emergency Room	$150 Copayment (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)
PHYSICIAN BENEFITS	
Payment level for Surgical/ Medical Covered Services	
— In-Network	80% of the Maximum Allowance
— Out-of-Network	50% of the Maximum Allowance
Payment level for Covered Services received in a Professional Provider's Office	
— **In-Network**	$30 per visit, then 100% of the Maximum Allowance, no deductible
Payment level for Emergency Accident Care when rendered by a Physician	80% of the Maximum Allowance no deductible
Payment level for Emergency Medical Care when rendered by a Physician	80% of the Maximum Allowance no deductible
OTHER COVERED SERVICES	
Payment level	80% of the Eligible Charge or Maximum Allowance

PRESCRIPTION DRUG PROGRAM BENEFITS

Copayment for drugs and supplies

— Generic Drugs and generic diabetic supplies	$10 per prescription
— Formulary Brand Name Drugs and Formulary brand name diabetic supplies	$40 per prescription
— Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies	$60 per prescription

Home Delivery Prescription Drug Program

Copayment for drugs and supplies

— Generic Drugs and generic diabetic supplies	$20 per prescription
— Formulary Brand Name Drugs and Formulary brand name diabetic supplies	$80 per prescription
— Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies	$120 per prescription

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

DEFINITIONS SECTION

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

ADVANCED PRACTICE NURSE.....means a Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation 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. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE.....means the amount that represents the billed charges from the majority of the ambulance Providers in the Chicago metro area, as submitted to Blue Cross and Blue Shield of Illinois.

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.

A "Plan Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of a Plan Ambulatory Surgical Facility.

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

APPROVED CLINICAL TRIAL.....means 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:

(i) A federally funded or approved trial;

(ii) A clinical trial conducted under an FDA experimental/investigational new drug application, or

(iii) A drug that is exempt from the requirement of an FDA experimental/investigational new drug application.

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

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

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorders.

BLUE*CHOICE*®.....means a network of selected Providers established by Blue Cross and Blue Shield.

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

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

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

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

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

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

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

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

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

(iii) is a graduate of an advanced practice nursing program.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d)

is recertified every two years by the Council on Recertification of Nurse Anesthetists.

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

CHIROPRACTOR.....means a duly licensed chiropractor.

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

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

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

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

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

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions

and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

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

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

CONGENITAL OR GENETIC DISORDER.....means a disorder that includes, but is not limited to, hereditary disorders, Congenital or Genetic Disorders may also include, but are not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

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.).

A "Plan Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time service is rendered to you.

A "Non-Plan Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with a Blue Cross and/or Blue Shield Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount 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 or Physician 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 Certificate begins.

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

CREDITABLE COVERAGE.....means coverage you had under any of the following:

(i) A group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

(iv) Medicaid (Title XIX of the Social Security Act).

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.

(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

(x) A health benefit plan under section 5(e) of the Peace Corps Act.

(xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

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.

A "Plan Dialysis Facility" means a Dialysis Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Dialysis Facility" means a Dialysis Facility which does not have an agreement with a Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

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

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

(i) the Provider's billed charges, or;

(ii) the Blue Cross and Blue Shield of Illinois non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Out-of-Network or Non-Plan Provider's standard billed charge for such Covered Services.

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

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for Out-of-Network or Non-Plan Providers will be 50% of the

Out-of-Network or Non-Plan Provider's standard billed charge for such Covered Service.

Blue Cross and Blue Shield of Illinois will utilize the same Claim processing rules and/or edits that it utilizes in processing In-Network Provider Claims for processing Claims submitted by Out-of-Network or Non-Plan Providers which may also alter the Eligible Charge for a particular service. In the event Blue Cross and Blue Shield of Illinois does not have any Claim edits or rules, Blue Cross and Blue Shield of Illinois may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Blue Cross and Blue Shield of Illinois within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an employee of the Group who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this Certificate.

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

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying 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 that the absence of immediate medical attention could result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

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 such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably ex-

pect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

ENROLLMENT DATE.....means the first day of coverage under your Group's health plan or, if your Group has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

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

(i) have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;

(ii) are appropriate for the Hospital or other Facility Provider in which the treatment or procedure were performed; and

(iii) the Physician or other Professional Provider has had the appropriate training and experience to provide the treatment or procedure.

The guidelines and practices of Medicare, Medicaid, or other government–financed programs shall be considered in determining whether any treatment, procedure, facility, equipment, drug device, or supply is Experimental/Investigational.

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

FAMILY COVERAGE.....means coverage for you and your eligible dependents under this Certificate.

GROUP POLICY or POLICY.....means the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, the Benefit Program Application of the Group and the individual applications of the persons covered under the Policy.

HABILITATIVE SERVICES....means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a treatment plan to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech–language 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.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service.

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

HOSPITAL.....means a duly licensed institution under state law for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses, irrespective of whether the institution provides Surgery on its premises or at another licensed hospital pursuant to a formal written agreement between the two institutions.

A “Plan Hospital” means a Hospital which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Plan Hospital” means a Hospital that does not meet the definition of a Plan Hospital.

INFERTILITY.....means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

INFUSION THERAPY.....means the administration of medication through a needle or catheter. It is prescribed when a patient’s condition is so severe that it cannot be treated effectively 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.

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

IN-NETWORK.....means a Covered Service is rendered by a Plan Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan or a Plan facility or Professional Provider which has been designated by a Blue Cross and/or Blue Shield Plan to provide services to participants in a benefit program that utilizes the Blue-Choice network.

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

INTENSIVE OUTPATIENT PROGRAM.....means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorders or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorders. Dual diagnosis programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that you will benefit from programs that focus solely on Mental Illness conditions. Dual diagnosis programs are delivered by Behavioral Health Practitioners who are cross-trained.

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorders. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute Inpatient, residential care or a Partial Hospitalization Treatment Program.

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 CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means

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

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist.

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

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers In-Network will be based on a Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. Benefit payments for Covered Services rendered by BlueChoice network Professional Providers will be based upon the applicable BlueChoice payment tier appropriate for that Provider. However, benefit payments for Covered Services rendered by Professional Providers in the PPO network, but not in the BlueChoice network will be based upon the Schedule of Maximum Allowances applicable to the PPO network which these Providers have agreed to accept as payment in full. (b) For Professional Providers Out-of-Network, the Maximum Allowance will be the lesser of:

(i) the Provider's billed charges, or;

(ii) the Blue Cross and Blue Shield of Illinois non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Out-of-Network Professional Provider's standard billed charge for such Covered Services.

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

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Maximum Allowance for Out-of-Network Professional Providers will be 50% of the Out-of-Network Professional Provider's standard billed charge for such Covered Service.

Blue Cross and Blue Shield of Illinois will utilize the same Claim processing rules and/or edits that it utilizes in processing In-Network Professional Provider Claims for processing Claims submitted by Out-of-Network Professional

Providers which may also alter the Maximum Allowance for a particular service. In the event Blue Cross and Blue Shield of Illinois does not have any Claim edits or rules, Blue Cross and Blue Shield of Illinois may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Blue Cross and Blue Shield of Illinois within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

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

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

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that Blue Cross and Blue Shield will pay the cost of the hospitalization, services or supplies.

Blue Cross and Blue Shield will make the initial decision whether hospitalization or other health care services or supplies were not Medically Necessary. In most instances this initial decision is made by Blue Cross and Blue Shield AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED. In making decisions of whether the hospitalization or other health care service(s) or supply(ies) are not Medically Necessary, and therefore not eligible for payment under the terms of your Certificate, Blue Cross and Blue Shield will take into account the information submitted to Blue Cross and Blue Shield by your Provider(s), including any consultations with such Providers(s).

Hospitalization or other health care is not Medically Necessary when, applying the definition of Medical Necessary to the circumstances surrounding the hospitalization or other health care, it is determined that, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue

Shield's initial decision, your benefit program provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so as described in the HOW TO FILE A CLAIM section of this Certificate.

Below are some examples, not an exhaustive list, of hospitalization or other health care services and supplies that are not Medically Necessary:

— Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.

— Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.

— Hospitalization or admission to a Skilled Nursing Facility or Residential Treatment Center, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.

— The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

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

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

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

MENTAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits including Preauthorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review

for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Use Disorders.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

"Serious Mental Illness".....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

(i) Schizophrenia;

(ii) Paranoid and other psychotic disorders;

(iii) Bipolar disorders (hypomanic, manic, depressive and mixed);

(iv) Major depressive disorders (single episode or recurrent);

(v) Schizoaffective disorders (bipolar or depressive);

(vi) Pervasive developmental disorders;

(vii) Obsessive-compulsive disorders;

(viii) Depression in childhood and adolescence;

(ix) Panic disorder;

(x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and

(xi) Anorexia nervosa and bulimia nervosa.

NAPRAPATH.....means a duly licensed naprapath.

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

NON-PLAN HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PLAN PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

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

OPTOMETRIST.....means a duly licensed optometrist.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

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

OUT-OF-NETWORK.....means a Covered Service is rendered by a Plan Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois to provide services to participants in a benefit program that utilizes the BlueChoice network.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Blue Cross and Blue Shield approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

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

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PLAN HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PLAN PROVIDER.....SEE DEFINITION OF PROVIDER.

PODIATRIST.....means a duly licensed podiatrist.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION RE-

VIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this Certificate.

PREEXISTING CONDITION.....means any disease, illness, sickness, malady or condition for which medical advice, diagnosis, care or treatment was received or recommended by a Provider within 6 months prior to your Enrollment Date. Taking prescription drugs is considered medical treatment even if your condition was diagnosed more than 6 months before your Enrollment Date. For purposes of this definition, pregnancy or conditions based solely on genetic information are not preexisting conditions.

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

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

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.

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.

A "Participating Provider" means a Plan Hospital, Plan facility or Professional Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in a BlueChoice program utilizing the BlueChoice network utilizing the Blue Choice Options network or a Plan facility or Professional Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider.

A "Professional Provider" means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider designated by Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan.

A "Participating Professional Provider" means a Professional Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to partici-

pants in a Participating Provider Option program or a Professional Provider who has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Professional Provider.

A "Non-Participating Professional Provider" means a Professional Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to participants in a Participating Provider Option program. For purposes of the provision of this Certificate entitled "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED," a Non-Participating Provider means a Non-Participating Professional Provider.

A "Participating Prescription Drug Provider" means a Pharmacy that has a written agreement with a Blue Cross and/or Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide services to you at the time you receive the services.

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

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

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

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

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

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

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

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

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

Routine Patient Costs do not include:

(i) The investigational item, device, or service, itself;

(ii) 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

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SERIOUS MENTAL ILLNESS.....SEE DEFINITION OF MENTAL ILLNESS.

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.

A "Plan Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan but has been certified in accordance with guidelines established by Medicare.

An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of a Plan Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

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

SPEECH THERAPIST.....means a duly licensed speech therapist.

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

SUBSTANCE USE DISORDER.....means chemical dependency and/or the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. 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 retardation or

learning disabilities, care in lieu of detention or correctional placement or family retreats.

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

A "Plan Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility that does not meet the definition of a Plan Substance Use Disorder Treatment Facility.

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 Blue Cross and Blue Shield.

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 jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex 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.

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

ELIGIBILITY SECTION

This Certificate contains information about the health care benefit program for the persons in your Group who:

- Meet the definition of an Eligible Person as specified in the Group Policy;
- Live within Blue Cross and Blue Shield of Illinois' service area;
- Have applied for this coverage; and
- Have received a Blue Cross and Blue Shield ID card.

If you meet this description of an Eligible Person, you are entitled to the benefits of this program.

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 Policy and were covered under the prior group policy will be considered Eligible Persons under this Certificate.

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

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

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

NOTIFICATION OF ELIGIBILITY CHANGES

It is the Eligible Person's responsibility to notify Blue Cross and Blue Shield of any change to an Eligible Person's name or address or other changes to eligibility. Such changes may result in coverage/benefit changes for you and your eligible family members.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the Eligibility Section above and you are eligible for Medicare and not affected by the "Medicare Secondary Payer" (MSP) laws as described below, the benefits described in this Certificate apply to you and to your spouse and covered dependent children (if

he or she is also eligible for Medicare and not affected by the MSP laws). Your benefit payments under this Certificate will be determined according to the rules described in the Coordination of Benefits Section of this Certificate.

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

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

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

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.

YOUR MSP RESPONSIBILITIES

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

YOUR BLUE CROSS AND BLUE SHIELD ID CARD

You will receive a Blue Cross and Blue Shield identification card. This card will tell you your Blue Cross and Blue Shield identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

FAMILY COVERAGE

If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age 26 will be covered.

Enrolled unmarried children will be covered up to age 30 if they:

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

If your child becomes ineligible, his or her coverage will end on the last day of the period for which premium has been accepted.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

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

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

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

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

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

- Marriage.
- Becoming party to a Civil Union.
- Birth, adoption or placement for adoption of a child.

- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:
    a. The other coverage was in effect when you were first eligible to enroll for this coverage;
    b. The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
    c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

  This includes, but is not limited to, loss of coverage due to:
    a. Legal separation, divorce, dissolution from a Civil Union, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;
    b. In the case of HMO coverage, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;
    c. Reaching a lifetime limit on all benefits in another group health plan;
    d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;
    e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
    f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

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

- Marriage.
- Becoming party to a Civil Union.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

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

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

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

Your Family Coverage or the coverage for your additional dependents will be effective no later than the first of the month after the special enrollment request is received if you apply within 60 days of any of the following events:

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

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later then the first of the month after the special enrollment request is received.

Late Applicants

If you do not apply for Family Coverage or to add dependents within the required number of days of the event, you will have to wait until your Group's annual open enrollment period to make those changes. Such changes will be effective on a date that has been mutually agreed to by your Group and Blue Cross and Blue Shield.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this Certificate if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Group terminates.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this Certificate or as specified below when your entire Group's coverage terminates. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this Certificate, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached).

Upon the death of an Eligible Person, dependents under his or her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person's coverage, provided such person makes payment for coverage.

Other options available for continuation of coverage are explained in the Continuation of Coverage After Termination Sections of this Certificate.

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

Extension of Benefits In Case of Discontinuance

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

CONVERSION PRIVILEGE

If your coverage under this Certificate should terminate and you want to continue Blue Cross and Blue Shield coverage with no interruption, you may do so if you have been insured under this coverage for at least 3 months and your Group has not cancelled this coverage and replaced it with other coverage. Here is what to do:

1. Tell Blue Cross and Blue Shield or your Group Administrator that you wish to continue your coverage and you will be provided with the necessary application.
2. Send the application and first premium to Blue Cross and Blue Shield within 31 days of the date you leave your Group or within 15 days after you have been given written notice of the conversion privilege, but in no event later than 60 days after you leave your Group.

Having done so, you will then be covered by Blue Cross and Blue Shield on an individual "direct pay" basis. This coverage will be effective from the date your Group coverage terminates so long as the premiums charged for the direct pay coverage are paid when due.

These direct pay benefits (and the premium charged for them) may not be exactly the same as the benefits under this Certificate. However, by converting your coverage, your health care benefits are not interrupted and you will not have to repeat waiting periods (if any).

Should any or all of your dependents become ineligible for coverage under this Certificate, they may convert to direct pay coverage by following the instructions stated above.

MEDICAL SERVICES ADVISORY PROGRAM

Blue Cross and Blue Shield has established the Medical Services Advisory Program (MSA) to perform a review of the following Covered Services **prior to** such services being rendered:

- Inpatient Hospital services
- Skilled Nursing Facility services
- services received in a Coordinated Home Care Program
- Private Duty Nursing Services

The MSA Program is staffed primarily by registered nurses and other personnel with clinical backgrounds. The Physicians in our Medical Department are an essential part of the MSA Program.

Failure to contact the MSA or to comply with the determinations of the MSA will result in a reduction in benefits. The MSA's toll-free telephone number is on your Blue Cross and Blue Shield identification card. Please read the provisions below very carefully.

> **NOTE: When you choose to receive Covered Services, from Provider in Illinois, you will not be responsible for notifying the MSA, and the provisions of this MSA PROGRAM section will not apply to you.**

The provisions of the MSA PROGRAM section do not apply to the treatment of Mental Illness and Substance Use Disorder Rehabilitation Treatment. The provisions for the treatment of Mental Illness and Substance Use Disorder Rehabilitation Treatment are specified in the BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT section of this Certificate.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate.

  Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are not Medically Necessary, it will be referred to a Blue Cross and Blue Shield Physician for review. If the Blue Cross and Blue Shield Physician concurs that the proposed admission or health care services are not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The MSA will issue these notifica-

tion letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

  Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate.

  In the event of an emergency admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Certificate, notify the MSA no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Maternity Admission Review**

  Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Certificate.

  In the event of a maternity admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Certificate, notify the MSA no later than two business days after the admission has occurred in order to have the Inpatient Hospital admission reviewed. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

  Even though you are not required to call the MSA prior to your maternity admission, if you call the MSA as soon as you find out you are pregnant, the MSA will begin to monitor your case. When you contact the MSA, you will be asked to answer a series of questions regarding your pregnancy. The MSA will provide you with educational materials which will be informative for you and which you may want to discuss with your Physician. A letter will be sent to your Physician stating that you contacted the MSA. The MSA will monitor your case and will be available should you have questions about your maternity benefits.

- **Skilled Nursing Facility Preadmission Review**

  Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate.

  Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least one business day prior to the scheduling of the admission. When you call the MSA, a case manager may be assigned to you for the duration of your care.

- **Coordinated Home Care Program Preadmission Review**

  Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate.

  Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least one business day prior to the scheduling of the admission. When you call the MSA, a case manager may be assigned to you for the duration of your care.

- **Private Duty Nursing Service Review**

  Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate.

  Whenever Private Duty Nursing Service is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least one business day prior to receiving services. When you call the MSA, a case manager may be assigned to you for the duration of your care.

CASE MANAGEMENT

After your case has been evaluated, you may be assigned a case manager. In some cases, if your condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan.

Alternative benefits will be provided only so long as Blue Cross and Blue Shield determines that the alternative services are Medically Necessary and cost effective. The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Certificate.

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

LENGTH OF STAY/SERVICE REVIEW

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

Upon completion of the preadmission or emergency review, the MSA will send you a letter confirming that you or your representative called the MSA. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

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

MEDICALLY NECESSARY DETERMINATION

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

The MSA does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The MSA's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under this Certificate.

In the event that Blue Cross and Blue Shield determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, Blue Cross and Blue Shield will not be responsible for any related Hospital or other health care service charge incurred.

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

MSA PROCEDURE

When you contact the MSA, you should be prepared to provide the following information:

1. the name of the attending and/or admitting Physician;
2. the name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;

3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the MSA, the MSA:

1. will review the medical information provided and may follow up with the Provider;
2. may determine that the services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

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

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

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

You must exercise the right to this appeal as a precondition to taking any action against Blue Cross and Blue Shield, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to Blue Cross and Blue Shield as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by Blue Cross and Blue Shield, if you request an appointment in writing.

Within 30 days of receiving your request for review, Blue Cross and Blue Shield will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

FAILURE TO NOTIFY

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

Should you fail to notify the MSA as required in the Preadmission Review provision of this section, you will then be responsible for the first $1,000 or 50%, whichever is less, of the Hospital or facility charges for an eligible stay or $1,000 or 50%, whichever is less, of the charges for eligible Covered Ser-

vices for Private Duty Nursing in addition to any deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate.

MEDICARE ELIGIBLE MEMBERS

The provisions of this Medical Services Advisory Program do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Certificate.

BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT

The Blue Cross and Blue Shield Mental Health Unit has been established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits, including Preauthorization review, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for your Inpatient Hospital admissions and/or Outpatient services for the treatment of Mental Illness and Substance Use Disorders. The Mental Health Unit has staff which includes Physicians, Psychologists, Clinical Social Workers and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO PREAUTHORIZE OR NOTIFY.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

  Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate.

  In order to receive maximum benefits under this Certificate, you must Preauthorize your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

  Emergency Mental Illness or Substance Use Disorder Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate.

  In order to receive maximum benefits under this Certificate, you or someone on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission

for the treatment of Mental Illness or Substance Use Disorder has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

- **Partial Hospitalization Treatment Program Preauthorization Review**

  Partial Hospitalization Treatment Program Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate.

  In order to receive maximum benefits under this Certificate, you must Preauthorize your treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment by calling the Mental Health Unit. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the scheduling of the Partial Hospitalization Treatment Program. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

  If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after Outpatient service(s), in order to receive maximum benefits under this Certificate, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

- **Length of Stay/Service Review**

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

  Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

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

- **Outpatient Service Preauthorization Review**

Outpatient service Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate.

In order to receive maximum benefits under this Certificate for Outpatient services for the treatment of Mental Illness or Substance Use Disorder, you must Preauthorize the following Outpatient service(s) by calling the Mental Health Unit:

- Psychological testing
- Neuropsychological testing
- Electroconvulsive therapy
- Intensive Outpatient Programs
- Repetitive Transcranial Magnetic Stimulation

In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the scheduling of the planned Outpatient service. The Mental Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after an Outpatient service, in order to receive maximum benefits under this Certificate, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission, Outpatient service, or other health care services or supplies are not Medically Necessary, as such term is defined in this Certificate, will be determined by the Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions from coverage under this Certificate, see the provision entitled, "EXCLUSIONS—WHAT IS NOT COVERED."

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Mental Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, Outpatient service, or other health care service or supply is Medically Necessary under this Certificate.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient Hospital admission, Outpatient service, or other health care service or supply is not Medically Necessary, Blue Cross and Blue Shield will not be responsible for any related Hospital or other health care service or supply charge incurred.

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

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;

2. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagree with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

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

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, TX 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against Blue Cross and Blue Shield, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to Blue Cross and Blue Shield as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by Blue Cross and Blue Shield, if you request an appointment in writing.

Within 30 days of receiving your request for review, Blue Cross and Blue Shield will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental

Health Unit has been established for the specific purpose of assisting you in maximizing your benefits provided under this Certificate.

Should you fail to Preauthorize or notify the Mental Health Unit as required in the Preauthorization Review provision of this section, you will then be responsible for the first $1,000 or 50%, whichever is less, of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this Certificate, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by an In-Network Provider in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as Blue Cross and Blue Shield determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Certificate.

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

MEDICARE ELIGIBLE MEMBERS

The provisions of the BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Certificate.

BENEFIT INFORMATION

Your employer has chosen a Blue Cross and Blue Shield Participating Provider Option benefit program for your Hospital and Physician benefits that provides you access to the BlueChoice network. This program of health care benefits is designed to provide you with economic incentives for receiving Covered Services In-Network.

As a participant in this benefit program, a directory of Providers participating in the BlueChoice network will be available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at *www.bcbsil.com* for a list of Participating Providers. While there may be changes in the network list from time to time, selection of Providers by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Group Administrator annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under this benefit program will be greater when you receive services In-Network.

This section of your Certificate tells you what services are covered and how much will be paid for each of these services.

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

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

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

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

YOUR BENEFIT PERIOD

Your 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 benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a $500 deductible for Covered Services In-Network and a separate $2,000 deductible for Covered Services Out-of-Network or from Non-Plan Provider(s). In other words, after you have Claims for Covered Services for more than the deductible amount in a benefit period, your

benefits will begin. This deductible will be referred to as the program deductible.

Each time you are admitted to a Hospital Out-of-Network or a Non-Plan Hospital, you must satisfy a $300. This deductible is in addition to your program deductible.

If you have any expenses for Covered Services during the last three months of a benefit period which were or could have been applied to that benefit period's program deductible, these expenses may be applied toward the program deductible of the next benefit period.

If you have Family Coverage and 3 members of your family have each satisfied their program deductible, it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet the program deductible before receiving benefits.

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

HOSPITAL BENEFIT SECTION

INPATIENT CARE

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

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
   - — a semi-private room
   - — a private room
   - — an intensive care unit
2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

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

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

Partial Hospitalization Treatment Program

Benefits are available for this program only if it is a Blue Cross and Blue Shield approved program. Covered Services rendered in a Non-Plan Provider facility will be paid at the Out-of-Network Provider facility payment level. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield.

Coordinated Home Care Program

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

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

In-Network

Benefits will be provided at 80% of the Hospital's Eligible Charge after you have met your program deductible when you receive Inpatient Covered Services In-Network or in a Coordinated Home Care Program In-Network. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds. If a private room is medically necessary, benefits will be based on the Hospital's private room and board rate.

Out-of-Network

When you receive Inpatient Covered Services Out-of-Network, benefits will be provided at 50% of the Eligible Charge, after you have met your program deductible and your Inpatient Hospital admission deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds. If a private room is medically necessary, benefits will be based on the Hospital's private room and board rate.

Non-Plan Provider

When you receive Inpatient Covered Services from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible and your Inpatient Hospital admission deductible.

Benefits for an Inpatient Hospital admission Out-of-Network or to a Non-Plan Provider resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level which you would have received had you been In-Network for that portion of your Inpatient Hospital stay during which your Medically Necessary condition is determined to be serious and therefore not permitting your safe transfer to a Hospital In-Network or other Provider In-Network.

Benefits for an Inpatient Hospital admission Out-of-Network or to a Non-Plan Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Out-of-Network Hospital payment level or the Non-Plan Hospital payment level (depending on the type of Provider) for that portion of your Inpatient Hospital stay during which your Medically Necessary condition is determined not to be serious and therefore permitting your safe transfer to a Hospital In-Network or other Provider In-Network.

Benefits for an Inpatient Hospital admission Out-of-Network or to a Non-Plan Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Out-of-Network Hospital payment level or the Non-Plan Hospital payment level (depending on the type of Provider) for that portion of your Inpatient Hospital stay during which your Medically Necessary condition is determined not to be serious and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

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

OUTPATIENT HOSPITAL CARE

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

Outpatient Hospital Covered Services

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

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

2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care
8. Emergency Medical Care
9. Mammograms—Benefits for routine mammograms will be provided at the benefit payment level described under the Routine Mammograms provision in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.
10. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females at the benefit payment level described under the Wellness Care provision in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
11. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment level described under the Wellness Care provision in the SPECIAL CONDTIONS AND PAYMENTS section of this Certificate.
12. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination at the benefit payment level described under the Wellness Care provision in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
13. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening, including colonoscopy and sigmoidoscopy, as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

    Benefits for colorectal cancer screening will be provided at the benefit payment level described under the Wellness Care provision in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will

be provided at the benefit payment level for Surgery described in this Certificate.

14. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.
15. Benefits for Routine Patient Costs for Participants in Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life–Threatening Disease or Condition and is recognized under state and/or federal law.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

In-Network

Benefits will be provided at 80% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services In-Network.

Benefits for routine diagnostic tests (other than routine mammograms) In-Network will be provided at 100% of the Hospital's Eligible Charge and will not be subject to the program deductible. Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

Out-of-Network

When you receive Outpatient Hospital Covered Services Out-of-Network, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.

Non-Plan Provider

When you receive Outpatient Hospital Covered Services from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Plan Provider will be paid at the same payment level which would have been paid had such services been received from a Provider In-Network.

Emergency Care

Benefits for Emergency Accident Care will be provided at 80% of the Eligible Charge when you receive Covered Services either In-Network, Out-of-Network or from a Non-Plan Provider.

Benefits for Emergency Accident Care will not be subject to the program deductible.

Benefits for Emergency Medical Care will be provided at 80% of the Eligible Charge when you receive Covered Services either In-Network, Out-of-Network or from a Non-Plan Provider.

Benefits for Emergency Medical Care will not be subject to the program deductible.

Each time you receive Covered Services in an emergency room, you will be responsible for a Copayment of $150. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible. The emergency room Copayment will not apply.

WHEN SERVICES ARE NOT AVAILABLE IN-NETWORK (HOSPITAL)

If you must receive Medically Necessary Hospital Covered Services which are determined to be unavailable from a Provider In-Network, benefits for the Covered Services you receive from a Provider Out-of-Network will be provided at the payment level described for a Provider In-Network.

PHYSICIAN BENEFIT SECTION

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

COVERED SERVICES

Surgery

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

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

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for Anesthesia Services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

   In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.
2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery when performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective).

Additional Surgical Opinion

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

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Substance Use Disorder Treatment Facility, a Residential Treatment Center or a Skilled Nursing Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home.

Consultations

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

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will 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, operating within the scope of his/her license. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Well Child Care

Benefits will be provided for Covered Services provided by a Physician to children under age 16, even though they are not ill. Benefits will be limited to the following services:

1. immunizations;
2. physical examinations;
3. routine diagnostic tests.

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis.

Radiation Therapy Treatments

Electroconvulsive Therapy

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician. Benefits for clinical breast examinations will be provided at the benefit payment level described under the Wellness Care provision in the SPECIAL CONDTIONS AND PAYMENTS section of this Certificate.

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

pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Benefits will also be provided for all Medically Necessary pain medication related to the treatment of breast cancer as described in the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION of this Certificate.

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

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

Mammograms—Benefits for routine mammograms will be provided at the benefit payment described under the Routine Mammograms provision in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females at the benefit payment level described under the Wellness Care provision in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

Human Papillomavirus Vaccine—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. Benefits will be provided at the benefit payment level for immunizations described under either the Well Child Care provision or the Wellness Care provision of this Certificate, whichever applies to you. If you purchase the vaccine at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate.

Shingles Vaccine—Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration at the benefit payment level described under the Wellness Care provision in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment level described under the Wellness Care provision of this Certificate.

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Benefits for ovarian cancer screening will be provided at the benefit payment level described under the Wellness Care provision in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

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

Benefits for colorectal cancer screening will be provided at the benefit payment level described under the Wellness Care provision in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedure will be provided at the benefit payment level for Surgery described in this Certificate.

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

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

Emergency Accident Care

Emergency Medical Care

Chiropractic and Osteopathic Manipulation

Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 30 visits per benefit period.

Durable Medical Equipment

Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by Blue Cross and Blue Shield. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary

therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

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

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

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

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, 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.

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

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

Massage Therapy

Tobacco Use Screening and Smoking Cessation Counseling Services

Tobacco Cessation Drugs

Growth Hormone Therapy

Breast Implant Removal

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

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services In-Network or Out-of-Network and whether services are provided by a Participating or Non-Participating Professional Provider. In most cases, your benefits will be greater when you receive services In-Network.

In-Network

When you receive any of the Covered Services described in this Physician Benefit Section from an In-Network Professional Provider or from a Dentist, benefits will be provided at 80% of the Maximum Allowance, unless otherwise specified in this Certificate. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this Certificate and may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

When you receive Covered Services (except for those services specified below) in an In-Network Professional Provider's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to a Copayment of $30 per visit. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

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

- Surgery
- Occupational Therapy
- Physical Therapy
- Speech Therapy

- MRI, CT Scan, pulmonary function studies,and cardiac catheterization and swan ganz catheterization
- Allergy injections and allergy testing

When you receive Covered Services for well child care In-Network, benefits will be provided at 100% of the Maximum Allowance subject to the Physician office visit Copayment.

Benefits for well child care In-Network will not be subject to the program deductible.

When you receive Covered Services, from an In-Network Hospital or from a Plan Ambulatory Surgical Facility and, due to any reason, Covered Services for anesthesiology, pathology, radiology, neonatology or emergency room are unavailable from an In-Network Provider and Covered Services are provided by an Out-of-Network Provider, you will incur no greater out-of-pocket costs than you would have incurred if the Covered Services were provided by an In-Network Provider.

However, in the event that you willfully choose to receive Covered Services from an Out-of-Network Provider when a Participating Professional Provider is available, or you or the Out-of-Network Provider reject the assignment of benefits, the above provision will not apply to you.

Out-of-Network

When you receive any of the Covered Services described in this Physician Benefit Section from a Professional Provider Out-of-Network, benefits will be provided at 50% of the Maximum Allowance, after you have met your program deductible, unless specifically mentioned below.

Emergency Care

Benefits for Emergency Accident Care will be provided at 80% of the Maximum Allowance when rendered In-Network or Out-of-Network. Your program deductible will not apply.

Benefits for Emergency Medical Care will be provided at 80% of the Maximum Allowance when rendered In-Network or Out-of-Network. Your program deductible will not apply.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible. The office visit Copayment will not apply.

Participating Professional Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists

- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

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

Non-Participating Professional Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors

- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

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

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

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

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

If two or more surgical procedures are related or are performed in the same operative area, and are performed on different dates by the same or a different Physician, Dentist or Podiatrist, benefits will be based upon the procedure which has the largest Maximum Allowance and 50% of the Maximum Allowance for the procedure which has the next largest allowance.

Procedures performed for conditions resulting from the same accident or injury are considered related.

If a surgical procedure is repeated during an Inpatient stay, the benefit payment will be based upon 50% of the Maximum Allowance for such repeat procedure and only one such repeat will be considered a Covered Service.

OTHER COVERED SERVICES

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

- The processing, transporting, storing, handling and administration of blood
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of 15 visits per benefit period.
- Hearing Aids—Benefits will be provided for bone anchored hearing aids.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.

Notwithstanding anything else described herein, Providers of ambulance services will be paid based on the amount that represents the billed charges from the majority of the ambulance Providers in the Chicago Metro area, as submitted to Blue Cross and Blue Shield of Illinois. Benefits for Ambulance Transportation will be paid at the highest level available under this benefit program. However, you will be responsible for any charges in excess of this amount.

When you receive Other Covered Services either In-Network or Out-of-Network benefits for Other Covered Services will be provided at the payment

levels previously described in this Certificate for Hospital and Physician Covered Services.

The expenses that are your responsibility for your Other Covered Services will depend on whether you receive services In-Network or Out-of-Network and whether services are provided by a Participating or Non-Participating Professional Provider.

Participating Professional Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

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

Non-Participating Professional Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

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

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

SPECIAL CONDITIONS AND PAYMENTS

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

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

— If both the donor and recipient have Blue Cross and Blue Shield coverage each will have their benefits paid by their own Blue Cross and Blue Shield program.

— If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

— the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

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

— **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact Blue Cross and Blue Shield by telephone before your transplant Surgery has been scheduled. Blue Cross and Blue Shield will furnish you with the names of Hospitals which have Blue Cross and Blue Shield approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Blue Cross and Blue Shield approved Human Organ Transplant Coverage Program.**

— Your benefits under this coverage will begin no earlier than 5 days prior to the transplant Surgery and shall continue for a period of no longer than

365 days after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.

— If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Certificate, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than miles from the Hospital where the transplant will be performed.

  - You and your companion are each entitled to benefits for lodging up to a maximum of $50 per day.
  - Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.

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

  - Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
  - Travel time and related expenses required by a Provider.
  - Drugs which do not have approval of the Food and Drug Administration.
  - Storage fees.
  - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
  - Meals.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits will be provided for cardiac rehabilitation services when rendered to you within a six month period following an eligible Inpatient Hospital admission, based on medical Policy. Benefits will 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.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to persons age 16 and over, even though they are not ill. Benefits will be limited to the following services:

1. Immunizations.
2. Routine physical examinations – one per benefit period.
3. Routine gynecological examinations – one per benefit period.
4. Routine diagnostic tests (other than routine mammograms), ordered or received on the same day as the examination. Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

In-Network

Benefits for wellness care In-Network will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance and will not be subject to the program deductible when Covered Services are received from a Provider other than in a Physician's office.

Benefits for routine diagnostic tests In-Network will be provided at 100% of the Eligible Charge or Maximum Allowance and will not be subject to the program deductible or Copayment.

When you receive Covered Services for wellness care In-Network in a Professional Provider's office, benefits for Covered Services will be provided at 100% of the Maximum Allowance and are subject to a Copayment of $30 per visit.

Out-of-Network

Benefits for wellness care Out-of-Network will be provided at 50% of the Eligible Charge or 50% of the Maximum Allowance after you have met your program deductible.

The following Covered Services are not subject to the wellness care benefit maximum: Pap smear test, prostate test and digital rectal examination, colorectal cancer screening, ovarian cancer screening, clinical breast examination, human papillomavirus vaccine and shingles vaccine.

SKILLED NURSING FACILITY CARE

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

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

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

Benefits for Covered Services rendered in a Plan Skilled Nursing Facility will be provided at 80% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Plan Skilled Nursing Facility will be provided at 50% of the Eligible Charge, once you have met your pro-

gram deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

AMBULATORY SURGICAL FACILITY

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

Benefits for services rendered by a Plan Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services by a Non-Plan Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT

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

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorders. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Medical Care for the treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Plan Provider facility will be paid at the Out-of-Network facility payment level.

DETOXIFICATION

Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received fore detoxification will be provided at the payment levels described in the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Certificate.

BARIATRIC SURGERY

Benefits for Covered Services for bariatric Surgery will be provided at the Hospital and Physician payment levels described in the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Certificate.

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 when rendered (A) by a Physician, a Psychologist, or other licensed health care Provider who has determined that such care is Medically Necessary, or (B) by a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be Medically Necessary and ordered by a Physician, a Psychologist or other licensed health care Provider.

Treatment for Autism Spectrum Disorder(s) shall include:

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

HABILITATIVE SERVICES

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

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

Congenital, Genetic, and Early Acquired Disorders may include, but are not limited to, autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

MATERNITY SERVICE

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

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

patient Hospital nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. (If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, benefits will be available for that care from the moment of birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage. You may apply for Family Coverage within 31 days of the date of the birth. Your Family Coverage will then be effective from the date of the birth.)

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

Your coverage also includes benefits for elective abortions if legal where performed.

INFERTILITY 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, low tubal ovum transfer and intracytoplasmic sperm injection.

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

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

Benefits for treatments that include oocyte retrievals will be provided only when:

— You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless; and

— You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

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

The maximum number of completed oocyte retrievals that are eligible for coverage under this Certificate in your lifetime is six. If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count as one completed oocyte retrieval. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.

Special Limitations

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

ROUTINE MAMMOGRAMS

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

— one baseline mammogram

— an annual mammogram

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

If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening of an entire breast or breasts, when determined to be medically necessary by your Physician.

In-Network

Benefits for routine mammograms when rendered by an In-Network Provider will be provided at 100% of the Eligible Charge or Maximum Allowance whether or not you have met your program deductible. Benefits for routine mammograms In-Network will not be subject to the Physician office visit Copayment.

Out-of-Network

Benefits for routine mammograms when rendered by an Out-of-Network Provider will be provided at 50% of the Eligible Charge or 50% of the Maximum Allowance after you have met your program deductible.

Benefit Maximum

Benefits for routine mammograms will not be subject to any benefit period maximum or lifetime maximum.

MASTECTOMY-RELATED SERVICES

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

1. Reconstruction of the breast on which the mastectomy has been performed;

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

PAYMENT PROVISIONS

Lifetime Maximum

The total dollar amount that will be available in benefits for you is unlimited subject to the separate dollar maximums for specific Covered Services described earlier in this Certificate.

Cumulative Benefit Maximums

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

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received In-Network and Out-of-Network.

In-Network

If, during one benefit period, your In-Network out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $2,000, any additional In-Network eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services received Out-of-Network or rendered by a Non-Plan Provider other than Emergen-

cy Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

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

- the program deductible(s)
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services received Out-of-Network or rendered by a Non-Plan Provider
- charges for Outpatient prescription drugs
- the Hospital emergency room Copayment
- the Copayment for Physician office visits
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit
- and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed

If you have Family Coverage and 3 members of your family have reached their In-Network out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.

Out-of-Network

If, during one benefit period, your Out-of-Network out-of-pocket expense (the amount remaining unpaid after Out-of-Network benefits have been provided) equals $8,000, any additional eligible Out-of-Network Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

- the payments for Covered Services received Out-of-Network for which you are responsible after benefits have been provided

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

- the program deductible(s)
- the Inpatient Hospital admission deductible(s)
- charges that exceed the Eligible Charge or Maximum Allowance

- the Coinsurance resulting from In-Network Covered Services
- the Coinsurance resulting from Hospital services rendered by a Non-Plan Hospital or other Non-Plan Provider facility for Covered Services
- charges for Outpatient prescription drugs
- the Hospital emergency room Copayment
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit
- any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period

If you have Family Coverage and 3 members of your family have reached their Out-of-Network out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program, Residential Treatment Facility or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

HOSPICE CARE PROGRAM

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

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

The following services are covered under the Hospice Care Program:

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

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

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

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

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Covered Services.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This Benefit Section of your Certificate explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

Although you can go to the Pharmacy of your choice, your benefits for drugs and supplies will be greater when you obtain them from a Participating Pharmacy. You can visit the Blue Cross and Blue Shield Web site at *www.bcbsil.com* for a list of Participating Pharmacies or call the customer service toll-free number on your identification card. The Pharmacies that are Participating Pharmacies may change from time to time. You should check with your Pharmacy before obtaining drugs or supplies to make certain of its participation status.

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

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

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

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

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

COMPOUND DRUGS.....means those drugs or inert ingredients that have been measured and mixed with United States Food and Drug Administration (FDA)-approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form.

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

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

(i) Which is Medically Necessary and is ordered by a Health Care Practitioner naming you as the recipient;

(ii) For which a written or verbal Prescription Order is provided by a Health Care Practitioner;

(iii) For which a separate charge is customarily made;

(iv) Which is not entirely consumed or administered at the time and place that the Prescription Order is written;

(v) For which the FDA has given approval for at least one indication; and

(vi) Which is dispensed by a Pharmacy and is received by you while covered under this Benefit Section, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the EXCLUSIONS provision later in this Benefit Section).

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

(i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or

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

FORMULARY BRAND NAME DRUG.....means a Brand Name prescription drug product that is identified on the *Formulary Drug List* and is subject

to the Formulary Brand Name Drug payment level. The *Formulary Drug List* is available by accessing the Web site at *www.bcbsil.com*.

GENERIC DRUG.....means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding payment level, Blue Cross and Blue Shield utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information.Generic Drugs are available by accessing the Web site at *www.bcbsil.com*. You may also contact customer service for more information.

HEALTH CARE PRACTITIONER.....means an Advanced Practice Nurse, doctor of medicine, doctor of dentistry, physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

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

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

NATIONAL DRUG CODE (NDC).....means a national classification system for the identification of drugs.

NON-FORMULARY BRAND NAME DRUG.....means a Brand Name Drug which does not appear on the *Formulary Drug List* and is subject to the Non-Formulary Brand Name Drug payment level. The *Formulary Drug List* is available by accessing the Web site at *www.bcbsil.com*.

NON-PARTICIPATING PHARMACY OR NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER.....means an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which has not entered into a written agreement with Blue Cross and Blue Shield to provide pharmaceutical services to you or an entity which has not been chosen by Blue Cross and Blue Shield to administer its prescription drug program services to you at the time you receive the services.

PARTICIPATING PHARMACY OR PARTICIPATING PRESCRIPTION DRUG PROVIDER.....means an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which has entered into a written agreement with Blue Cross and Blue Shield to provide pharmaceutical services to you or an entity chosen by Blue Cross and Blue Shield to administer its prescription drug program services to you at the time you receive the services.

PHARMACY.....means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription 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.

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 DRUGS.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, you should contact your Pharmacy, refer to the *Formulary Drug List* by accessing the Web site at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

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

ABOUT YOUR BENEFITS

Formulary Drug List

Formulary drugs are selected by Blue Cross and Blue Shield based upon the recommendations of a committee, which is made up of current and previously practicing physicians and pharmacists from across the country, some of whom are employed by or affiliated with Blue Cross and Blue Shield. The committee considers drugs regulated by the FDA for inclusion on the formulary. As part of the process, the committee reviews data from clinical studies, published literature and opinions from experts who are not part of the committee. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the formulary.

The committee considers drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to this list can be made from time to time.

The *Formulary Drug List* and any modifications will be made available to you. Blue Cross and Blue Shield may offer multiple formularies. By accessing the Web site at *www.bcbsil.com* or calling the customer service toll-free number on your identification card, you will be able to determine the *Formulary Drug List* that applies to you and whether a particular drug is on the *Formulary Drug List*. Drugs that do not appear on the *Formulary Drug List* are subject to the Non-Formulary Brand Name Drug payment level plus any pricing differences that may apply to the Covered Drug you receive.

When certain medications and drug classes, such as medications used to treat rheumatoid arthritis, growth hormone deficiency, hepatitis C, and more serious forms of anemia, hypertension, asthma, epilepsy, and psoriasis are prescribed,

your Physician will be required to obtain authorization from Blue Cross and Blue Shield. Medications included in this program are subject to change and other medications for other conditions may be added to the program. Although you may currently be on therapy, your Claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the brand name medication.

Blue Cross and Blue Shield'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. If you do not obtain prior authorization, you will then be responsible for the first $1,000 or 50% of the Eligible Charge, whichever is less, when you obtain Covered Drugs through a retail Pharmacy or $1,000 or 50% of the Eligible Charge, whichever is less, when you obtain Covered Drugs through the Home Delivery Prescription Drug Program.

To find out more about prior authorization/step therapy requirements or to determine which drugs or drug classes require prior authorization or step therapy, you should contact your Pharmacy or refer to the *Formulary Drug List* by accessing the Web site at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

Dispensing Limits

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, coverage will only be provided for a clinically appropriate pre-determined maximum quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

The maximum quantity of a given prescription drug means the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, you can refer to the *Formulary Drug List* by accessing the Web site at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

If you require a Prescription Order in excess of the dispensing limit established by Blue Cross and Blue Shield, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. Blue Cross and Blue Shield 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.

Day Supply

In order to be eligible for coverage under this Certificate, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation prescribed in the Certificate. Payment for benefits covered under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Specialty Drugs are limited to a 30 day supply.

Controlled Substance Limitation

If Blue Cross and Blue Shield determines that you are receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized treatment guidelines, any additional drugs may be subject to a review for medical necessity and restricted to a certain Provider and/or Pharmacy for the prescribing and dispensing of the controlled substance medication.

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 at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed:
    a. a prescription drug reference compendium approved by the Department of Insurance, or
    b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the FDA, such drugs, unless the intended use is specifically excluded in this Benefit Section, are eligible for benefits. Some equivalent drugs are manufactured under multiple brand names. In such cases, Blue Cross and Blue Shield may limit benefits to only one of the brand equivalents available.

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

Injectable Drugs

Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

Benefits are available for Medically Necessary immunosuppressant drugs with a written prescription after an approved Human Organ Transplant.

Diabetic Supplies for Treatment of Diabetes

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

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

Compound Drugs

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

(i) The drugs in the compounded product are FDA approved;

(ii) The approved product has an assigned National Drug Code (NDC); and

(iii) The primary active ingredient is a Covered Drug under this Benefit Section.

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

Cancer Medications

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

Self-Administered Cancer Medications

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

Specialty Drugs

Benefits are available for Specialty Drugs as described under **Specialty Pharmacy Program**.

SELECTING A PHARMACY

When you choose to go to a Participating Pharmacy:

- present your identification card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- pay the applicable deductible, if any, and
- pay the appropriate Copayment Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

Participating Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Eligible Charge, or
- the amount for which you are responsible for as described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

You may be required to pay for limited or non-Covered Services. No Claim forms are required if you follow the above procedures.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access the Web site at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

Non-Participating Pharmacy

If you choose to have a Prescription Order filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a Claim form to Blue Cross and Blue Shield or to the prescription drug administrator with itemized receipts verifying that the Prescription Order was filled. Blue Cross and Blue Shield will reimburse you for Covered Drugs equal to:

- the Coinsurance Amount indicated,
- less the amount for which you are responsible for as described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

Please refer to the provision entitled “Filing Outpatient Prescription Drug Claims” in the HOW TO FILE A CLAIM section of this Certificate.

The Home Delivery Prescription Drug Program provides delivery of Covered Drugs directly to your home address. In addition to the benefits described in this Benefit Section, your coverage includes benefits for Maintenance Drugs and

diabetic supplies obtained through the Home Delivery Prescription Drug Program.

Some drugs may not be available through the Home Delivery Prescription Drug Program. For a listing of Maintenance Drugs or if you have any questions about the Home Delivery Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the home delivery order form, you may access the Web site at *www.bcbsil.com* or call the customer service toll-free number on your identification card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

When you obtain Maintenance Drugs through the Home Delivery Prescription Drug Program, benefits will be provided according to the **Home Delivery Prescription Drug Program** payment provision described later in this Benefit Section.

For information about the Home Delivery Prescription Drug Program, contact your employer or group administrator.

Specialty Pharmacy Program

This program provides delivery of medications directly to your Health Care Practitioner, administration location or to your home if you are undergoing treatment for a complex medical condition. To determine which drugs are Specialty Drugs or to locate a Specialty Pharmacy Provider, you should refer to the *Formulary Drug List* by accessing the Web site at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

The Specialty Pharmacy Program delivery service offers:

- Coordination of coverage between you, your Health Care Practitioner and Blue Cross and Blue Shield,
- Educational materials about the patient's particular condition and information about managing potential medication side effects,
- Syringes, sharp containers, alcohol swabs and other supplies with every shipment of FDA approved self-injectable medications, and
- Access to a pharmacist 24 hours a day, 7 days a week, 365 days each year.

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

BENEFIT PAYMENT FOR PRESCRIPTION DRUGS

Retail Pharmacy

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

When you obtain Covered Drugs, including diabetic supplies from a Participating Pharmacy, you must pay a Copayment Amount of:

- **$10 for each prescription** – for Generic Drugs and diabetic suppliesand generic diabetic supplies and generic.
- **$40 for each prescription** – for Formulary Brand Name Drugs and Formulary brand name diabetic supplies.
- **$60 for each prescription** – for Non-Formulary Brand Name Drugs and Non-Formulary brand name diabetic supplies.

When you obtain Covered Drugs, including diabetic supplies from a Non-Participating Pharmacy (other than a Participating Pharmacy), benefits will be provided at % of the amount you would have received had you obtained drugs from a Participating Pharmacy, minus the Copayment Amount.

One prescription means up to a 30 consecutive day supply of a drug. Certain drugs may be limited to less than a 30 consecutive day supply. However, for certain Maintenance Drugs, larger quantities may be obtained through the Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Pharmacy or call the customer service toll-free number on your identification card. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Home Delivery Prescription Drug Program

When you obtain Covered Drugs, including diabetic suppliesthrough the Home Delivery Prescription Drug Program, you must pay a Copayment Amount of:

- **$20 for each prescription** – for Generic Drugs and generic diabetic supplies and generic diabetic supplies.
- **$80 for each prescription** – for Formulary Brand Name Drugs and Formulary brand name.
- **$120 for each prescription** – for Non-Formulary Brand Name Drugs and Non-Formulary brand name diabetic supplies.

Under the Home Delivery Prescription Drug Program, one prescription means up to a 90 consecutive day supply of a drug. Certain drugs may be limited to less than a 90 consecutive day supply.

Specialty Pharmacy Program

When you obtain covered Specialty Drugs from a Provider who is not a Specialty Pharmacy Provider, 75% of the Eligible Charge will be paid, minus the Copayment Amount.

EXCLUSIONS

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

1. 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.
2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).
3. Administration or injection of any drugs.
4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
5. 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.
6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
7. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
8. Drugs which are repackaged by a company other than the original manufacturer.
9. 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 more than one year following the Prescription Order date.
10. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
11. 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) in-

jection 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.

12. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
13. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
14. 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.
15. 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.
16. Compounded drugs that do not meet the definition of Compound Drugs in this portion of your Benefit Section or that are determined to be high-risk compounds.
17. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
18. 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 by Blue Cross and Blue Shield.
19. Athletic performance enhancement drugs.
20. Allergy serum and allergy testing materials.
21. Some equivalent drugs manufactured under multiple brand names. Blue Cross and Blue Shield may limit benefits to only one of the brand equivalents available.
22. Drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives.
23. Medications in depot or long acting formulations that are intended for use longer than the covered days supply amount.

EXCLUSIONS—WHAT IS NOT COVERED

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

— **Hospitalization, or health care services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not Medically Necessary as defined by this Certificate.

— Services or supplies that are not specifically mentioned in this Certificate.

— 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.

— 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 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.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under this Certificate for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this Certificate if not provided in connection with a qualified clinical cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Care Program.

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this Certificate.

— 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. This 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).

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

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

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

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this Certificate.

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

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye which are not Medically Necessary, except as specifically mentioned in this Certificate.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

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

— Immunizations, unless otherwise specified in this Certificate.

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

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under this Certificate for Autism Spectrum Disorder(s).

— Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services, except as they relate to Autism Spectrum Disorder(s).

— Hearing aids, except for bone anchored hearing aids (osseointegrated auditory implants), or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Certificate.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Experimental/Investigational unless otherwise specified in this Certificate.

— Residential Treatment Centers, except for Inpatient Substance Use Disorder Rehabilitation Treatment or Inpatient Mental Illness and as specifically mentioned under this Certificate.

— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

— Wigs (also referred to as cranial prostheses), unless otherwise specified in this Certificate.

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.

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

COORDINATION OF BENEFITS SECTION

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

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

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but
2. May be reduced when, under the order of 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 the above definition unless your stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Benefit Program.

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

BENEFIT PROGRAM.....means any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(i) Group insurance or group–type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.

(ii) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION

When there is a basis for a Claim under this Benefit Program and another Benefit Program, this Benefit Program is a Secondary Program which 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 which applies:

1. Non-Dependent or Dependent

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

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

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

2. Dependent Child if Parents not Separated or Divorced

   Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a dependent of different persons, called "parents:"

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

b. If both parents have the same birthday, the benefits of the program which covered the parents longer are determined before those of the program which covered the other parent for a shorter period of time.

However, if the other Benefit Program does not have this birthday-type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of benefits, the rule in the other Benefit Program will determine the order of benefits.

3. Dependent Child if Parents Separated or Divorced

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

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

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

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

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

4. Dependent Child if Parents Share Joint Custody

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

5. Active or Inactive Employee

The benefits of a Benefit Program which 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 which covered 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 is ignored.

6. 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 rule, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

7. Length of Coverage

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

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

1. The benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made;

Exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Benefit Program will be reduced so that they and the benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

If you are eligible for Medicare Part B, the benefits of this Benefit Program may be reduced taking into consideration the amount that would be payable for an Allowable Expense under Medicare Part B whether or not you have enrolled in Part B and/or received payment from Medicare.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

CONTINUATION OF 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 (see definition) 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 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 of coverage if you are the Eligible Person**

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

1. Continuation of coverage will be available to you only if you have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least 3 months prior to your termination date or reduction in hours below the minimum required for eligibility.
2. Continuation of coverage will not be available to you if: (a) you are covered by Medicare, except if you have been covered under a group Medicare supplement policy, or (b) you have coverage under any other health care program which provides group hospital, surgical or medical coverage and under which you were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility, or (c) you decide to become a member of Blue Cross and Blue Shield on a "direct pay" basis.
3. If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by Blue Cross and Blue Shield for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this

charge must be made to Blue Cross and Blue Shield (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.

4. If you decide to become a member of Blue Cross and Blue Shield on a "direct pay" basis, you may not, at a later date, elect the continuation of coverage option under this Certificate. Upon termination of the continuation of coverage period as explained in paragraph 6 below, the provisions of this Certificate pertaining to "Extension of Benefits in Case of Termination" will apply and you may exercise the Conversion Privilege explained in the ELIGIBILITY SECTION of this Certificate.

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

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

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

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

    c. The date on which the Group Policy is terminated. However, if this Certificate is replaced by similar coverage under another group policy, the Eligible Person will have the right to become covered under the new coverage for the amount of time remaining in the continuation of coverage period. When your continuation of coverage period has expired, the provisions of this Certificate entitled EXTENSION OF BENEFITS IN CASE OF TERMINATION (when applicable) will apply to you.

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

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

1. Continuation will be available to you as the former spouse of an Eligible Person or spouse of a retired Eligible Person only if you provide the employer of the Eligible Person with written notice of the dissolution of marriage or Civil Union, the death or retirement of the Eligible Person within 30 days of such event.
2. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to Blue Cross and Blue Shield of the dissolution of your marriage or Civil Union to the Eligible Person, the death of the Eligible Person or the retirement of the Eligible Person as well as notice of your address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:
    a. a form for election to continue coverage under this Certificate.
    b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
    c. instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.
3. In the event you fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Eligible Person under this Certificate as a result of the dissolution of marriage or Civil Union, the death or the retirement of the Eligible Person. Your right to continuation of coverage will then be forfeited.
4. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Eligible Persons under this Certificate.

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

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

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

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

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 of Coverage:

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

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

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

   c. the date on which you remarry or enter 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 of coverage shall end on the first to occur of the following:

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

   b. on the date coverage would otherwise terminate, except due to the retirement of the Eligible Person, under this Certificate if you were still married to or in a Civil Union with the Eligible Person; however,

your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death, retirement or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.

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

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

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

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

10. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.

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

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

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

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

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

3. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to Blue Cross and Blue Shield of the death of the Eligible Person or of the dependent child reaching the limiting age, as well as notice of the dependent child's address. Such notice will include

the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:

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

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

c. instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.

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

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

6. The monthly charge will be computed as follows:

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

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

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

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

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

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

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

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

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

9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.

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

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

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

Continuation of Coverage

If you are the party to a Civil Union or the dependent child of a party to a Civil Union 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 are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

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

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your 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.

Conversion Privilege

Upon termination of your continuation coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a "direct pay" basis as specified in the Conversion Privilege provision of the ELIGIBILITY SECTION of this Certificate.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to your dependent who is a party to a Civil Union and their children.

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

Introduction

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

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

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

What Is COBRA Continuation Coverage?

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

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

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

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

- Your spouse dies;

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his/her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

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

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

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

Disability Extension Of 18-Month Period Of Continuation Coverage

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is proper-

ly 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 Web site at *www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

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.

HOW TO FILE A CLAIM

In order to obtain your benefits under this Certificate, it is necessary for a Claim to be filed with Blue Cross and Blue Shield. To file a Claim, usually all you will have to do is show your Blue Cross and Blue Shield ID card to your Hospital or Physician (or other Provider) when you receive services. They will file your Claim for you. Remember however, it is your responsibility to insure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

Once Blue Cross and Blue Shield receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases Blue Cross and Blue Shield will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Group Administrator or from your local Blue Cross and Blue Shield office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

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

In any case, Claims should be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Group Administrator or call your local Blue Cross and Blue Shield office.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

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

1. Complete a prescription drug Claim Form. These forms are available from your Group Administrator or from your local Blue Cross and Blue Shield office.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield of Illinois
   P.O. Box 14624
   Lexington, KY 40512-4624

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.

INQUIRIES AND COMPLAINTS

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

A**"Complaint"** is an expression of dissatisfaction by you either orally or in writing. Blue Cross and Blue Shield has a team of professionals available to assist you with inquiries and complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of Care

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, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your case within 30 days of receipt by Customer Service. If Blue Cross and Blue Shield needs more information, you will be contacted. If a decision will be delayed due to the need for additional information, you will be contacted.

APPEALS

If you submit an inquiry or complaint and it is not resolved to your satisfaction, you may appeal the decision.

An appeal is an oral or written request for a review of an adverse decision or action by Blue Cross and Blue Shield or its employees. An appeal may be filed by you, a person designated to act on your behalf, or any health care provider.

No person reviewing the appeal may have been involved in the initial determination that is the subject of the appeal.

If an appeal is not resolved to your satisfaction, you may appeal Blue Cross and Blue Shield's decision to the Illinois Department of Insurance. Illinois Department of Insurance will notify Blue Cross and Blue Shield of the appeal. Blue Cross and Blue Shield will have 21 days to respond to the Illinois Department of Insurance.

URGENT/EXPEDITED CLINICAL APPEALS

An urgent/expedited clinical appeal is an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatment ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your health.

Upon receipt of an urgent/expedited pre-service or concurrent clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. Blue Cross and Blue Shield shall render a determination on the appeal within 24 hours after it receives the requested information.

CLINICAL APPEALS

A clinical appeal is an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that does not meet the definition of an urgent/expedited clinical appeal.

Upon receipt of a non-urgent pre-service or post-service clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of the request. Blue Cross and Blue Shield shall render a determination on the appeal within 15 business days after it receives the requested information but in no event more than 30 days after the appeal has been received by Blue Cross and Blue Shield.

NOTIFICATION

Blue Cross and Blue Shield will notify the party filing the appeal, you, and any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notification will include:

- A clear and detailed reason for the determination.
- Medical or clinical criteria used in the determination.
- Procedures for requesting an external independent review, if your appeal is denied.

INDEPENDENT EXTERNAL REVIEW

An **"Adverse Determination"** means a determination by Blue Cross and Blue Shield or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered

benefit has been reviewed and, based upon the information provided, does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated.

A **"Final Adverse Determination"** means an adverse determination involving a covered benefit that has been upheld by Blue Cross and Blue Shield or its designated utilization review organization, at the completion of Blue Cross and Blue Shield's internal grievance process procedures as set forth by the Managed Care Reform and Patient Rights Act.

EXPEDITED INDEPENDENT EXTERNAL REVIEW

If you have a medical condition where the timeframe for completion of a) an expedited internal review of a grievance involving an Adverse Determination; b) a Final Adverse Determination as set forth in the Managed Care Reform and Patient Rights Act; or, c) a standard external review as set forth in the Managed Care Reform and Patient Rights Act, would seriously jeopardize your life or health or your ability to regain maximum function, then you have the right to have the Adverse Determination or Final Adverse Determination reviewed by an independent review organization not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you may request an expedited independent external review.

You may also request an expedited external review if the treatment or service in question has been denied on the basis that it 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.

Your request for an expedited independent external review may be submitted orally or in writing. Upon receipt of your request, an independent review organization registered with the Illinois Department of Insurance will be assigned to review Blue Cross and Blue Shield's decision.

Within two business days after the date of receipt of all necessary information, the expedited independent external reviewer will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and you will receive notification from Blue Cross and Blue Shield. The decision of the external independent reviewer is final. Until July 1, 2013, if you disagree with the determination of the external independent reviewer, you may contact the Illinois Department of Insurance.

STANDARD EXTERNAL INDEPENDENT REVIEW

You must submit a written request for an external independent review within four months of receiving an Adverse Determination or Final Adverse Determination of a clinical appeal. You may submit additional information or documentation to support your request for the health care services.

Within five business days of receipt of your request, BlueCross and Blue Shield will complete a preliminary review to determine whether:

- you or your dependent was a covered person at the time health care services were requested or provided;
- the service that is the subject of the Adverse Determination or the Final Adverse Determination was a Covered Service under this Certificate but Blue Cross and Blue Shield has determined that the health care service does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness
- you have exhausted Blue Cross and Blue Shield's internal grievance process; and
- you have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service under this Certificate, except for Blue Cross and Blue Shield's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under this Certificate. In addition, the licensed Physician who ordered or provided the services in question has certified that one of the following situations is applicable:

- standard health care services or treatments have not been effective in improving your condition;
- standard health care services or treatments are not medically appropriate;
- there is no available standard health care services or treatment covered by Blue Cross and Blue Shield that is more beneficial than the recommended or requested service or treatment;
- 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
- 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.

Within one business day after completion of the preliminary review, Blue Cross and Blue Shield shall notify you or your designated representative in writing whether the request is complete and is eligible for an external review. If the request is not complete or not eligible for an external review, you shall be notified by Blue Cross and Blue Shield in writing of what materials are required or the reason for ineligibility.

Within five business days of determining that a request is eligible for an external review, Blue Cross and Blue Shield shall a) assign an independent review or-

ganization from the list of approved independent review organizations; and b) notify you or your designated representative of the request's eligibility and acceptance for an external review and the name of the independent review organization.

Within five business days upon the assignment of an external independent review organization, Blue Cross and Blue Shield or its designated utilization review organization, shall provide to the external independent reviewer the documents and any information considered in making the Adverse Determination or Final Adverse Determination.

Within five business days after the date of receipt of the necessary information, the external independent reviewer will render a decision based on whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and you will receive notification from Blue Cross and Blue Shield. The decision of the external independent reviewer is final. Until July 1, 2013, if you disagree with the determination of the external independent reviewer, you may appeal the decision of the external independent review organization to the Illinois Department of Insurance at 866-445-5364.

Benefits will not be provided for services or supplies not covered under your Certificate even if the external independent reviewer determines that the health care services being appealed were medically appropriate.

NON-CLINICAL APPEALS

A non-clinical appeal is an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

Upon receipt of a pre-service or post-service non-clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of the request. Blue Cross and Blue Shield shall render a decision on the appeal within 15 business days after it receives the requested information.

NOTIFICATION

Blue Cross and Blue Shield will notify you and the party filing the non-clinical appeal orally of its determination, followed-up by a written notice of determination.

The written notification will include:

- A clear and detailed reason for the determination.
- Contractual, administrative or protocol for the determination.

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:

In addition, if you have an adverse appeal determination, you may file civil action in a state or federal court.

INITIAL CLAIMS DETERMINATIONS

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

If a Claim Is Denied or Not Paid in Full

If the claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

a. The reasons for determination;

b. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;

c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

e. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

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

g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield;

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

i. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline,

protocol or other similar criterion will be provided free of charge on request;

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

k. In the case of a denial of an urgent care clinical Claim a description of the expedited review procedure applicable to such claims. An urgent care Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification; and

l. Contact information for applicable office of health insurance consumer assistance or ombudsman.

INQUIRIES AND COMPLAINTS

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

A **"Complaint"** is an expression of dissatisfaction by you either orally or in writing. Blue Cross and Blue Shield has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to the following:

- Claims
- Quality of care

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

To pursue an Inquiry or Complaint, you may contact Customer Service at the number on the back of your ID 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 response to your Inquiry or Complaint within 30 days of receipt. Sometimes the acknowledgement and the response will be combined. If Blue Cross and Blue Shield needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information you will be contacted.

Timing of Required Notices and Extensions

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

1. **Urgent Care Clinical Claim** is any pre-service claim that requires Preauthorization, as described in this Certificate, for benefit for medical care or treatment with respect to which the application of regular time periods for

making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without 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 Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information with Blue Cross and Blue Shield may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	**Timing**
If your claim is incomplete, Blue Cross and Blue Shield must notify you within:	24 hours**
If you are notified that your claim is incomplete, you must then provide competed Claim information to Blue Cross and Blue Shield within:	48 hours after receiving notice
Blue Cross and Blue Shield must notify you of the claim determination (whether adverse or not):	
If the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
After receiving the completed claim (if the initial claim is incomplete), within:	48 hours

* You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call Blue Cross and Blue Shield at the toll-Free number listed on the back of your ID card as soon as possible to appeal an Urgent Care Clinical Claim.

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

Pre-Service Claims

Type of Notice or Extension	**Timing**
If your claim is filed improperly, Blue Cross and Blue Shield must notify you within:	5 days*

If your claim is incomplete, Blue Cross and Blue Shield must notify you within:	15 days
If you are notified that your claim is incomplete, you must then provide completed claim information to Blue Cross and Blue Shield within:	45 days after receiving notice
Blue Cross and Blue Shield must notify you of the claim determination (whether adverse or not):	
If the initial claim is complete, within	15 days**
After receiving the completed claim (if the initial claim is incomplete), within:	30 days
If you require post-stabilization care after an Emergency within:	The time appropriate to the circumstance not to exceed one hour after the time of request

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

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

Post-Service Claims

Type of Notice or Extension	Timing
If your claim is incomplete, Blue Cross and Blue Shield must notify you within:	30 days
If you are notified that your claim is incomplete, you must then provide completed claim information to Blue Cross and Blue Shield within:	45 days after receiving notice
Blue Cross and Blue Shield must notify you of the claim determination (whether adverse or not):	
If the initial claim is complete, within:	30 days*
After receiving the competed claim (if the initial claim is incomplete), within:	45 days

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

Concurrent Care

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

CLAIM APPEAL PROCEDURES

Claim Appeal Procedures—Definitions

An "Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by Blue Cross and Blue Shield and Blue Cross and Blue Shield reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium. In addition, an Adverse Benefit Determination, also includes an "Adverse Determination."

An **"Adverse Determination"** means:

1. A determination by Blue Cross and Blue Shield or its designee utilization review organization that, based upon the information provided, a request for a benefit under Blue Cross and Blue Shield's health benefit plan upon application of any utilization review technique does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
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 Blue Cross and Blue Shield or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or
3. A rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as a continued hospitalization. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, Blue Cross and Blue Shield will provide you with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

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

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by Blue Cross and Blue Shield in accordance with the benefits and procedures detailed in your Health Benefit Plan. An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call Blue Cross and Blue Shield at the number on the back of your ID card.

If you believe Blue Cross and Blue Shield incorrectly denied all or part of your benefits, you may have your claim reviewed. Blue Cross and Blue Shield will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to Blue Cross and Blue Shield to request a claim review. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-877-284-9302 or send your request to:

  Claim Review Section
  Health Care Service Corporation
  P.O. Box 2401
  Chicago, IL 60690–1364

- In support of your Claim review, you have the option of presenting evidence and testimony to Blue Cross and Blue Shield. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.

Blue Cross and Blue Shield will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rational and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. If the initial benefit determination regarding the claim is based in whole or part on medical judgment, the appeal will be conducted by individuals associated with Blue Cross and Blue Shield and/or external advisors, but who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by Blue Cross and Blue Shield.

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

Blue Cross and Blue Shield will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 days after the appeal has been received by Blue Cross and Blue Shield.

Blue Cross and Blue Shield will render a decision of the post-service appeal as soon as practical, but in no event more than 60 days after the appeal has been received by Blue Cross and Blue Shield.

Notice of Appeal Determination

Blue Cross and Blue Shield will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:

a. The reasons for the determination;

b. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

c. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if ap-

plicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

d. An explanation of Blue Cross and Blue Shield's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final decision on external appeal;

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

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

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

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

i. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and

j. A description of the standard that was used in denying the claim and a discussion of the decision.

k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

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

If an appeal is not resolved to your satisfaction, you may appeal Blue Cross and Blue Shield's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify Blue Cross and Blue Shield of the appeal. Blue Cross and Blue Shield will have 21 days to respond to the Illinois Department of Insurance.

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

The Illinois Department of Insurance can be contacted at:

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

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

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call Blue Cross and Blue Shield's Headquarters at 1-800-538-8833. Blue Cross and Blue Shield offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday.

Blue Cross and Blue Shield of Illinois
P.O. Box 2401
Chicago, IL 60690-1364

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 ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INDEPENDENT EXTERNAL REVIEW

You or your authorized representative may make a request for a standard external review or expedited external review of an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

A "Final Adverse Determination" means an Adverse Determination involving a Covered Service that has been upheld by Blue Cross and Blue Shield or its designated utilization review organization, at the completion of Blue Cross and Blue Shield's internal grievance process procedures.

1. Standard External Review

You or your authorized representative must submit a written request for an external independent review to the Director of the Illinois Department of Insurance ("Director") within four months of receiving an Adverse Determination or Final Adverse Determination. You may submit additional information or documentation to support your request for the health care services. Within one business day after the date of receipt of the request, the Director will send a copy of the request to Blue Cross and Blue Shield.

a. **Preliminary Review.** Within five business days of receipt of the request from the Director, Blue Cross and Blue Shield will complete a preliminary review of your request to determine whether:

- You were a covered person at the time health care service was requested or provided;
- The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this Certificate, but Blue Cross and Blue Shield has determined that the health care service is not covered;
- You have exhausted Blue Cross and Blue Shield's internal appeal process, unless you are not required to exhaust Blue Cross and Blue Shield's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and
- You have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Blue Cross and Blue Shiel's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, your health care provider has certified that one of the following situations is applicable:

- Standard health care services or treatments have not been effective in improving your condition;
- Standard health care services or treatments are not medically appropriate for you; or
- There is no available standard health care services or treatment covered by Blue Cross and Blue Shield that is more beneficial than the recommended or requested service or treatment.

In addition, a) your health care provider has certified in writing that the health care service or treatment is likely to be more beneficial to you, in the opinion of your health care provider, than any available standard health care services or treatments, or b) your health care provider who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.

Notification. Within one business day after completion of the preliminary review, Blue Cross and Blue Shield shall notify the Director, you and your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the Director, you and your authorized representative shall be notified by Blue Cross and Blue Shield in writing of what materials are required to make the request complete or the reason for its ineligibility. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the Director by filing a com-

plaint with the Director. The Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of your benefit program (unless such terms are inconsistent with applicable laws) and shall be subject to all applicable laws.

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

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

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

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

- Your pertinent medical records;

- Your health care provider's recommendation;
- Consulting reports from appropriate health care providers and other documents submitted to Blue Cross and Blue Shield or its designee utilization review organization, you, your authorized representative or your treating provider;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield or its designated utilization review organization; and
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

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

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

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

The written notice will include:

1. A general description of the reason for the request for external review;
2. The date the IRO received the assignment from the Director;
3. The time period during which the external review was conducted;
4. References to the evidence or documentation including the evidence-based standards, considered in reaching its decision or, in the case of external reviews of the experimental or investigational services or treat-

ments, the written opinions of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

5. The date of its decisions, and
6. The principal reason or reasons for its decision, including, what applicable, if any, evidence-based standards that were a basis for its decisions;and
7. The rationale for its decision.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program even if the IRO determines that the health care services being reviewed were medically appropriate.

The IRO is not bound by any claim determinations reached prior to the submission of information to the IRO. The Director, you and your authorized representative, if applicable, and Blue Cross and Blue Shield will receive written notice from the IRO. Until July 1, 2013, if you disagree with the determination of the IRO, you may appeal the decision of the IRO to the Illinois Department of Insurance.

2. Expedited External Review

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination; (b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of Final Adverse Determination or if Blue Cross and Blue Shield fails to provide a decision on request for an expedited internal appeal within 48 hours.

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

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

Your request for an expedited independent external review may be submitted to the Director either orally by calling 877-850-4740 or in writing as set forth above for requests for standard external review.

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

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

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

As expeditiously as your medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited external review) the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the Director, Blue Cross and Blue Shield, you and, if applicable, your authorized representative. If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the Director, Blue Cross and Blue Shield and, if applicable, your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of experimental or investigational treatments, each clinical review shall provide an opinion orally or in writing to the assigned IRO as expeditiously as your medical condition or circumstances requires, but in no event less than five calendar days after being selected. Within 48 hours after the date it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writ-

ing to the Director, the Claim Administrator, you and your authorized representative, if applicable.

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

The assigned IRO is not bound by any decisions or conclusions reached during Blue Cross and Blue Shield's utilization review process or Blue Cross and Blue Shield's internal grievance process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program if the IRO determines that the health care services being appealed were medically appropriate. Until July 1, 2013, if you disagree with the determination of the IRO, you may appeal the decision of the IRO to the Illinois Department of Insurance.

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

GENERAL PROVISIONS

1. BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers ("Plan Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under certain circumstances described in its contracts with Plan Providers, Blue Cross and Blue Shield may:

- receive substantial payments from Plan Providers with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Plan Provider, or
- pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Plan Providers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Certificate and the calculation of all required deductible and Coinsurance amounts payable by you under this Certificate shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Group has been advised that Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Providers work, please consider the following example:

a. 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?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your Certificate.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. 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.

e. After taking into account the deductible and Coinsurance amounts, Blue Cross and Blue Shield will satisfy its portion of the Hospital bill. In most cases, Blue Cross and Blue Shield has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money Blue Cross and Blue Shield would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then Blue Cross and Blue Shield has to satisfy the rest of the Hospital bill, or $860. Assuming Blue Cross and Blue Shield has a contract with the Hospital, Blue Cross and Blue Shield will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the $860 bill and whatever Blue Cross and Blue Shield ultimately pays under its contracts with Plan Providers, and neither you nor your Group are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

Out-of-Area Services

Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, herein called "the Plan" has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by Blue Cross and Blue Shield Association. Whenever you access healthcare services outside of the Plan's service area, the Claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program and may include negotiated arrangements available between the Plan and other Blue Cross and Blue Shield Licensees.

When you receive care outside our service area, you will receive it from two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain how we both types of Providers below.

BlueCard Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you receive Covered Services outside the Plan's service area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to the Plan.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your identification card to the Provider to let him/her know that you are covered by the Plan.

b. The Provider has negotiated with the Host Blue a price of $80, even though the Provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the Claim to the Plan and indicates that the negotiated price for the Covered Service is $80. The Plan would then base the amount you must pay for the service — the amount applied to your deductible, if any, and your Coinsurance percentage — on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your Coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a Covered Service.

PLEASE NOTE: The Coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no Copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this Certificate.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, also take into account adjustments to correct for over or underestimation of past pricing of Claims, as noted above. However, such adjustments will not affect the price we use for your

Claim because they will not be applied after a Claim has already been paid.

Non-Participating Healthcare Providers Outside the Plan's Service Area

a. Liability Calculation

(1) **In General**

When Covered Services are provided outside of the Plan's service area by Non-Participating Providers, the amount you pay for such services will be calculated using the methodology described in this Certificate for Non-Participating Providers located inside our service area. You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

(2) **Exceptions**

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

Special Cases: Value-Based Programs

BlueCard Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing and/or Care Coordinator Fees that are a part of such an arrangement, except when Host Blue passes these fees to the Plan through average or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If the Plan has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the employer on your behalf, the Plan will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted for the BlueCard Program.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Plan will include any such surcharge, tax or other fee as part of the Claim Charge passed on to you.

BlueCard Worldwide Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the BlueCard Worldwide Program when

accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the BlueCard Worldwide Service Center at 1-800-810.Blue(2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

If the Plan has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the employer on your behalf, the Plan will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted for the BlueCard Program.

- **Inpatient Services**

  In most cases, if you contact the BlueCard Worldwide Service Center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the BlueCard Worldwide Service Center to begin Claims processing. However if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact the Plan to obtain Preauthorization for non-emergency inpatient services.**

- **Outpatient Services**

  Outpatient Services are available for Emergency Care, Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a BlueCard Worldwide Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional Claims, you should complete a BlueCard Worldwide International claim form with the Provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate Claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Plan, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers

Blue Cross and Blue Shield hereby informs you that it has arrangements with prescription drug providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under its arrangements with Participating Prescription Drug Providers, Blue Cross and Blue Shield may receive from these providers discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of prescription drugs will vary. Some discounts are currently based on Average Wholesale Price ("AWP") which is determined by a third party and is subject to change.

You understand that Blue Cross and Blue Shield may receive such discounts. Neither the Group nor you are entitled to receive any portion of any discounts. The drug fees/discounts that Blue Cross and Blue Shield has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate your share of the cost of prescription drugs for both retail and home delivery/specialty drugs. Except for home delivery/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to the Plan (and ultimately to you as described above).

For the home delivery pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the home delivery pharmacy and/or specialty pharmacy program. Blue Cross and Blue Shield pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and home delivery processing.

"Weighted Paid Claim" refers to the methodology of counting claims for purposes of determining Blue Cross and Blue Shield's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim equals one Weighted Paid Claim; each extended supply or home delivery order paid claim equals three Weighted Paid Claims. However, Blue Cross and Blue Shield pays Prime a Program Management Fee ("PMF") on a per paid claim basis. "Funding Levers" means a mechanism though which Blue Cross and Blue Shield funds the fees (net fee, ancillary fees and special project fees) owed to PBM. Funding Levers always include manufacturer administrative fees, home delivery utilization, participating pharmacy transaction fees, and, if elected by Blue Cross and Blue Shield, may include rebates and retail spread. Blue Cross and Blue Shield's net fee owed to Prime for core services will be offset by the Funding Levers. Blue Cross and Blue Shield pays Prime

the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per Weighted Paid Claim.

The amounts received by Prime from Blue Cross and Blue Shield, 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 Blue Cross and Blue Shield (as described above), administrative fees charge 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 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of Blue Cross and Blue Shield and other Blue Plan operating divisions.

Blue Cross and Blue Shield's Separate Financial Arrangements with Pharmacy Benefit Managers

Blue Cross and Blue Shield owns a significant portion of the equity of Prime Therapeutics LLC and informs you that Blue Cross and Blue Shield has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on Blue Cross and Blue Shield's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of Blue Cross and Blue Shield, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). Blue Cross and Blue Shield may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Certificate, Blue Cross and Blue Shield has the right to make any benefit payment either to you or directly to the Provider of the Covered Services, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by Blue Cross and Blue Shield sufficiently in advance of Blue Cross and Blue Shield's benefit payment. Blue Cross and Blue Shield reserves the right to require submission of a copy of the Assignment of Benefit Payment. For example, Blue Cross and Blue Shield may pay benefits to you

if you receive Covered Services from a Non-Plan Provider. Blue Cross and Blue Shield is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request Blue Cross and Blue Shield not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, Blue Cross and Blue Shield will have no liability to you or any other person because of its rejection of such request.

c. Except for the assignment of benefit payment described above, neither this Certificate nor a Covered Person's claim for benefits under this Certificate is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Certificate is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.

b. Blue Cross and Blue Shield does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. Blue Cross and Blue Shield is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by Blue Cross and Blue Shield. Any contractual relationship between a Physician and a Plan Hospital or other Plan Provider shall not be construed to mean that Blue Cross and Blue Shield is providing professional service.

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

d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Group (other than as an individual Covered Person) or your Group's ERISA Health Benefit Program.

4. AGENCY RELATIONSHIPS

The Group is your agent under this Certificate. The Group is not the agent of Blue Cross and Blue Shield.

All information you and the Group provide to Blue Cross and Blue Shield will be relied upon as accurate and complete. The Group must promptly notify Blue Cross and Blue Shield of any changes to such information.

5. NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield under this Certificate must be in writing and sent to Blue Cross and Blue Shield at its offices at 300 East Randolph, Chicago, Illinois 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield's records or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records.

6. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate, prior to the expiration of sixty (60) days after a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate.

7. INFORMATION AND RECORDS

You agree that it is your responsibility to ensure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Certificate, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield or its agent, and agree that any such Provider, person or other entity may furnish to Blue Cross and Blue Shield or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish Blue Cross and Blue Shield and/or your employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that Blue Cross and Blue Shield be able to make Claim Payments in accordance with MSP laws.

8. VALUE BASED DESIGN PROGRAMS

Blue Cross and Blue Shield and your employer has the right to offer health behavior wellness, maintenance, or improvement programs that allow for a reward, a contribution, a penalty, a differential in premiums or in medical, prescription drug or equipment Copayments, Coinsurance, deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by 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 without notice.

Contact Blue Cross and Blue Shield for additional information regarding any value based programs offered by Blue Cross and Blue Shield. Contact your employer for additional information regarding any value based programs offered by your employer.

9. CONFORMITY WITH STATE STATUTES

This Certificate provides, at a minimum, coverage as required by Illinois law. Laws in some other states require that certain benefits or provisions be provided to you if you are a resident of their state when the policy that insures you is not issued in your state. In the event any provision of this Certificate, on its effective date, conflicts with the laws of the state in which you permanently reside, you will be provided the greater of the benefit under this Certificate or that required under the laws of the state in which you permanently reside.

10. MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Illinois, a division of Health Care Services Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, by the Host Blues whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise from involuntary termination of your health coverage sponsored by your Group but solely as a result of a reduction in force, plant/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Blue Cross and Blue Shield of Illinois offers to, you, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, Blue Cross and Blue Shield of Illinois may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Policy your Group has with Blue Cross and Blue Shield of Illinois to the extent reasonably neces-

sary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

11. ENTIRE CONTRACT

The entire contract consists of the Group Policy, including the agreement between Blue Cross and Blue Shield 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, benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Group Policy, to extend the time for payment of premiums, or to waive any of the rights or requirements of Blue Cross and Blue Shield. No modifications of the Group Policy will be valid unless evidenced by an endorsement or amendment of the Group Policy, signed by an officer of Blue Cross and Blue Shield and delivered to the Group.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in this Certificate, you agree:

a. Blue Cross and Blue Shield has the right to reimbursement for all benefits Blue Cross and Blue Shield provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which Blue Cross and Blue Shield has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

b. Blue Cross and Blue Shield is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits Blue Cross and Blue Shield provided for that sickness or injury.

Blue Cross and Blue Shield shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which Blue Cross and Blue Shield has provided benefits as a result of that sickness or injury.

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

BlueCross BlueShield of Illinois

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