Your Health Care Benefit Program

BLUE ADVANTAGE ENTREPRENEUR
A Blue Cross HMO

a product of

Blue Cross and Blue Shield of Illinois

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

HMO GROUP CERTIFICATE RIDER

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

A. All references to "Chemical Dependency" are hereby replaced with the term "Substance Use Disorder".

B. HOW TO FILE A CLAIM

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

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

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

If a Claim Is Denied or Not Paid in Full

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

a. The reasons for determination;

b. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;

c. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.

e. An explanation of the Plan's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

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

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

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

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

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

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

l. Contact information for applicable office of health insurance consumer assistance or ombudsman.

INQUIRIES AND COMPLAINTS

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

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

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

- Claims
- Quality of care

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

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

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

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

Timing of Required Notices and Extensions

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

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

b. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

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

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Plan must notify you within:	**24 hours****

If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Plan within:	**48 hours after receiving notice**
The Plan must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed Claim (if the initial Claim is incomplete), within:	**24 hours of receipt of completed Claim**

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

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

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, the Plan must notify you within:	**5 days***
If your Claim is incomplete, the Plan must notify you within:	**15 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Plan within:	**45 days after receiving notice**
The Plan must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete, within:	**15 days****
after receiving the completed Claim (if the initial Claim is incomplete), within:	**30 days**
If you require post-stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

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

** This period may be extended one time by the Plan for up to 15 days, provided that the Plan both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Post-Service Claims

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

* This period may be extended one time by the Plan for up to 15 days, provided that the Plan both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Concurrent Care

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

CLAIM APPEAL PROCEDURES

Claim Appeal Procedures - Definitions

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

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

An **"Adverse Determination"** means:

a. a determination by the Plan or its designated utilization review organization that, based upon the information provided, a request for a benefit under the Plan's health benefit plan upon application of any utilization review technique does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or it is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

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

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

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, Blue Cross and Blue Shield will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

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

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by the Plan in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care Provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain

an Authorized Representative Form, you or your representative may call the Plan at the number on the back of your identification card.

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

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Plan to request a Claim review. The Plan will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-800-538-8833 or send your request to:

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

- In support of your claim review, you have the option of presenting evidence and testimony to the Plan. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

  The Plan 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 rationale 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 in part on a medical judgement, the appeal will be conducted by individuals associated with the Plan and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Plan.

Timing of Non-Urgent Appeal Determinations

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

The Plan will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 15 business days after receipt of all required information (if the appeal is related to health care ser-

vices and not related to administrative matters or Complaints) or 30 days after the appeal has been received by the Plan, whichever is sooner.

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

Notice of Appeal Determination

The Plan will notify the party filing the appeal, you, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal, orally of its determination, followed-up by a written notice of the determination.

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

a. The reasons for the determination;

b. A reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;

c. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

d. An explanation of the Plan's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal appeal;

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

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

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

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

i. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;

j. A description of the standard that was used in denying the Claim and a discussion of the decision; and

k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

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

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

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

The Illinois Department of Insurance can be contacted at:

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

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

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the the Plan Headquarters at 1-800-538-8833. The Plan's offices are open from 8:45 a.m. To 4:45 p.m., Monday through Friday.

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

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9432, or call the number on the back of your identification card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INDEPENDENT EXTERNAL REVIEW

You or your authorized representative may make a request for a standard external review or expedited external review of an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

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

1. **Standard External Review**

   You or your authorized representative must submit a written request for a standard external independent review to the Director of the Illinois Department of Insurance ("Director") within 4 months of receiving an Adverse Determination or Final Adverse Determination. You may submit additional information or documentation to support your request for the health care services. Within one business day after the date of receipt of the request, the Director will send a copy of the request to the Plan.

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

   - You were a covered person at the time health care service was requested or provided;
   - The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this benefit program, but the Plan has determined that the health care service is not covered;
   - You have exhausted the Plan's internal appeal process, unless you are not required to exhaust the Plan's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and
   - You have provided all the information and forms required to process an external review.

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

   - Standard health care services or treatments have not been effective in improving your condition;
   - Standard health care services or treatments are not medically appropriate for you; or

- There is no available standard health care services or treatment covered by the Plan that is more beneficial than the recommended or requested service or treatment.
- In addition, a) your health care Provider has certified in writing that the health care service or treatment is likely to be more beneficial to you, in the opinion of your health care Provider, than any available standard health care services or treatments; or b) your health care Provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.

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

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

Within five business days after the date of receipt of the notice provided by the Director of assignment of an IRO, the Plan shall provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may, within five business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after five business days. If the Plan or its designated utilization review organization does not provide the documents and information within

five business days, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by the Plan or designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the external review. Within one business day after making the decision to end the external review, the IRO shall notify the Plan, you and, if applicable, your authorized representative, of its decision to reverse the determination.

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

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

- Your pertinent medical records;
- Your health care Provider's recommendation;
- Consulting reports from appropriate health care Providers and other documents submitted to the Plan or its designated utilization review organization, you, your authorized representative or your treating Provider;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence–based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan or its designated utilization review organization; and
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

Within one business day after the receipt of notice of assignment to conduct an external review with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the IRO will

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

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

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

The written notice will include:

1. A general description of the reason for the request for external review;
2. The date the IRO received the assignment from the Director;
3. The time period during which the external review was conducted;
4. References to the evidence or documentation including the evidence–based standards, considered in reaching its decision or, in the case of external reviews of experimental or investigational services or treatments, the written opinion of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
5. The date of its decisions;
6. The principal reason or reasons for its decision, including what applicable, if any, evidence–based standards that were a basis for its decision; and
7. The rationale for its decision.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination. 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, your authorized representative, if applicable, and the Plan will receive written notice from the IRO.

Standard External Review

Standard External Review	Timing
If you receive an Adverse Determination or a Final Adverse Determination, you may file a a request for an external review within:	**4 months after receipt of notice**
The Plan shall complete a preliminary review of the request within:	**5 business days after receiving request**
The Plan must notify you whether the request is complete and eligible for external review:	
if the request is not complete the Plan shall notify you and include what information or materials are required within:	**one business day after the preliminary review**
if the request is not eligible for external review the Plan shall notify you and include the reasons for its ineligibility within:	**one business day after the preliminary review**
The Plan shall notify the Director, you or your authorized representative that a request is eligible for external review within:	**one business day after the preliminary review**
The Director shall assign an independent review organization (IRO) within:	**1 business day after receipt of the notice**
The Plan shall provide to the assigned IRO the documents and any information used in making the Adverse Determination or Final Adverse Determination within:	**5 business days of notice of assigned IRO**
The IRO shall provide notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination within:	**5 days after receipt of all required information from you (but no more than 45 days after the receipt of request for external review)**

2. Expedited External Review

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination; (b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized

representative may file a request for an expedited external review by an IRO not associated with the Plan. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of a Final Adverse Determination of if the Plan fails to provide a decision on a request for an expedited internal appeal within 48 hours.

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

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

Your request for an expedited independent external review may be submitted to the Director either orally (by calling 877-850-4740) or in writing as set forth above for requests for standard external review.

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

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

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

Adverse Determination. Within one business day after making the decision to end the external review, the IRO shall notify the Director, the Plan, you and, if applicable, your authorized representative, of its decision to reverse the determination.

As expeditiously as your medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited external review), the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the Director, the Plan, you and, if applicable, your authorized representative. If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the Director, the Plan and, if applicable, your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of experimental or investigational treatments, each clinical reviewer shall provide an opinion orally or in writing to the assigned IRO as expeditiously as your medical condition or circumstances requires, but in no event less than five calendar days after being selected. Within 48 hours after the date it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing to the Director, the Plan, you and your authorized representative, if applicable.

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

The assigned IRO is not bound by any decisions or conclusions reached during the Plan's utilization review process or the Plan's internal appeal process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program if the IRO determines that the health care services being appealed were medically appropriate.

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

Expedited External Review

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

External Review of Experimental or Investigational Treatment

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

If your treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may make an oral request for an expedited external review, after which the Director shall immediately notify the Plan and the time frames otherwise applicable to Expedited External Review shall apply.	
After the receipt for an external review, the Director shall send a copy of the request to the Plan within:	**one business day**
The Plan shall complete a preliminary review of the request within:	**5 business days**
After completion of the preliminary review, the Plan shall notify you or your authorized representative and the Director whether the request is complete and eligible for external review within:	**one business day**
When the Director receives notice that the request is eligible for external review, the Director shall:	
assign an IRO and notify the Plan of the name of the IRO, within:	**one business day**
notify you or your authorized representative in writing of the request's eligibility and acceptance for external review and the name of the IRO, within:	**one business day**
If you are notified that your request for an external review has been accepted, you or your authorized representative may submit additional information to the assigned IRO within:	**5 business days**
The assigned IRO shall then select one or more clinical reviewers within:	**one business day**
The Plan shall provide to the assigned IRO the documents and any information used in making the Adverse Determination or Final Adverse Determination within:	**5 business days of notice of assigned IRO**
After being selected by the assigned IRO, each clinical reviewer shall provide an opinion to the assigned IRO on whether the recommended or request health care service shall be covered within:	**20 days**
or, in the case of an expedited external review:	**immediately, but in no event more than 5 calendar days**

The assigned IRO shall make a decision after receipt of the opinion from each clinical reviewer and provide notification of the decision to the Director, you or your authorized representative and the Plan within:	**20 days**
or, in the case of an expedited external review, within:	**48 hours after receipt of the opinion of each clinical reviewer**

C. OTHER THINGS YOU SHOULD KNOW

The following provision is hereby added:

MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, by the Host Blues whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by your Group, but solely as a result of a reduction in force, plant/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Blue Cross and Blue Shield of Illinois offers to, you, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, Blue Cross and Blue Shield of Illinois may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Policy the Group has with Blue Cross and Blue Shield of Illinois to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

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

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

President

HMO 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 Certificate for your and/or your spouse's enrolled child(ren) up to the age of 26.

"Child(ren)" used hereafter, means a natural child(ren), a stepchild(ren), a child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under your Certificate), 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. PRIMARY CARE PHYSICIAN

The second and third paragraphs under the **YOUR PRIMARY CARE PHYSICIAN** section are revised to read as follows:

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

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

D. PREVENTIVE SERVICES

The following provision is added to this Certificate:

Preventive Services

Preventive care services will be provided for the following Covered Services when ordered by your Primary Care Physician or Woman's Principal Health Care Provider will not be subject to any deductible, coinsurance, Copayment or benefit maximum:

a) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");

b) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

c) evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and

d) with respect to women, such additional preventive care and screenings, not described in item a above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described in items a through d above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Blue Cross and Blue Shield Web site at *www.bcbsil.com* or contact customer service at the toll-free number on your identification card.

Examples of Covered Services included are routine annual physicals, immunizations, routine pediatric care, cancer screening mammograms, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services and healthy diet counseling and obesity screening/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Covered Services not included in items a through d above will be subject to the deductible, coinsurance, Copayment and/or dollar maximums previously described in your Certificate, if applicable.

E. EMERGENCY SERVICES

Notwithstanding anything in your Certificate to the contrary, for emergency care benefits rendered by Providers who are not part of your HMO's network or otherwise contracted with HMO, the Provider's Charge shall be equal to the greatest of the following amounts:

1. the amount negotiated with Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the HMO generally uses to determine payments for services but substituting the cost-sharing provisions for the non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Copayment imposed with respect to the participant.

F. INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

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

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Plan will usually pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that the Plan does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Plan will usually notify you, your valid assignee or your authorized representative, when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the OTHER THINGS YOU SHOULD KNOW section of this Certificate.) If you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim [as defined below]). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If the Claim for benefits is denied in whole or in part, you will receive a notice from the Plan with the following time limits:

1. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.
2. For benefit determinations relating to urgent care/expedited clinical claim (as defined below), such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.

   An "urgent care/expedited clinical claim" is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
3. For non-urgent pre-service claims, within 15 days after receipt of the claim by the Plan. A "pre-service claim" is a non-urgent request for approval that the Plan requires you to obtain before you get medical care, such as Preauthorization or a decision on whether a treatment or procedure is medically necessary.
4. For post-service Claims, within 30 days after receipt of the Claim by the Plan. A "post-service claim" is a Claim as defined in the DEFINITIONS SECTION.

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 denial;

b. A reference to the benefit plan provisions on which the denial is based;

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), diagnosis, treatment and denial codes with their meanings and the standards used;

e. An explanation of the Plan's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

f. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);

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, and 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 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;

j. In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as written notice is furnished to the claimant with 3 days of oral notification; and

k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

INQUIRIES AND COMPLAINTS

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

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

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

- Claims
- Quality of care

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

To pursue an Inquiry or a Complaint, you may contact **Customer Service** at the number on the back of your ID card, or you may write to:

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

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of

receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If 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.

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

CLAIM APPEAL PROCEDURES - DEFINITIONS

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Plan at the number on the back of your ID card.

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 the Plan and the Plan reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

In addition, an Adverse Benefit Determination, also includes an "Adverse Determination." An **"Adverse Determination"** means a determination by the Plan or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet the Plan'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. 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.

A **"Final Internal Adverse Benefit Determination"** means an Adverse Benefit Determination that has been upheld by the Plan at the completion of the Plan's internal review/appeal process.

CLAIM APPEAL PROCEDURES

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. The Plan will review its decision in accordance with the following procedures. The following review procedures will also be used for the Plan (i) coverage determinations that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits and (ii) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as "appeals."

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Plan to request a claim review. The Plan will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-800-538-8833 or send your request to:

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

In support of your Claim review, you have the option of presenting evidence and testimony to the Plan, by phone or in person at a location of the Plan's choice. 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.

The Plan 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 rationale 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. The appeal will be conducted by individuals associated with the Plan and/or by external advisors, but who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits the claimant much exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Plan.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical claim, or health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Plan will provide you with notice and an opportu-

nity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, the Plan 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. The Plan shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by the Plan.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal the Plan shall render a determination of the appeal within 3 business days if additional information is needed to review the appeal. Additional information must be submitted within 5 days of the request. The Plan shall render a determination of 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 the Plan.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Plan's Headquarters at 1-800-538-8833. The Plan's offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

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

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, 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).

Notice of Appeal Determination

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

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. An explanation of the Plan's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
6. 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;
7. 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;
8. 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
9. A description of the standard that was used in denying the claim and a discussion of the decision.

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

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

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

The Illinois Department of Insurance can be contacted at:

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

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

INDEPENDENT EXTERNAL REVIEW

You or your authorized representative may make a request for a standard external or expedited external review of an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

An **"Adverse Determination"** means a determination by the Plan or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet the Plan'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 Service that has been upheld by the Plan or its designated utilization review organization, at the completion of the Plan's internal grievance process procedures.

1. **Standard External Review**

   You or your authorized representative must submit a written request for an external independent review within 4 months of receiving an Adverse Determination or Final Adverse Determination. You may submit additional information or documentation to support your request for the health care services.

   a. **Preliminary Review.** Within 5 business days of receipt of your request, the Plan will complete a preliminary review of your request to determine whether:

      - You were a covered person at the time health care service was requested or provided;
      - The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this benefit program, but the Plan has determined that the health care service does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
      - You have exhausted the Plan's internal grievance process (in certain urgent cases, you may be eligible for expedited external review even if you have not filed an internal appeal with the Plan, and, you may also be eligible for external review if you filed an internal appeal but have not received a decision from the Plan within 15 days after the Plan received all required information [in no case longer than 30 days after you first file the appeal] or within 48 hours if you have filed a request for an expedited internal appeal); and

- You have provided all the information and forms required to process an external review.

For external reviews relating to a determination based on treatment being experimental or investigational, the Plan will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for the Plan's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, the 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 for you;
- There is no available standard health care services or treatment covered by the Plan that is more beneficial than the recommended or requested service or treatment;
- 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.

b. Notification. Within 1 business day after completion of the preliminary review, the Plan shall notify 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, you shall be notified by the Plan in writing of what materials are required to make the request complete or the reason for its ineligibility. The Plan's determination that the external review request is ineligible for review may be appealed to the Illinois Director of the Department of Insurance ("Director") by filing a complaint with the ("Director"). The ("Director") may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of your benefit program and shall be subject to all applicable laws.

c. Assignment of IRO. If your request is eligible for external review, the Plan shall, within 5 business days (a) assign an IRO from the list of approved IROs; and (b) notify you and your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Upon assignment of an IRO, the Plan or its designated utilization review organization shall, within 5 business days, 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 5 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 5 business days. If the Plan or its designated utilization review organization does not provide the documents and information within 5 business days, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by the Plan or designated utilization review organization to provide the documents and information to the IRO within 5 business days shall not delay the conduct of the external review. Within 1 business day after making the decision to end the external review, the IRO shall notify the Plan, you and, if applicable, your authorized representative, of its decision to reverse the determination.

If you or your authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to the Plan within 1 business day of receipt from you or your authorized representative. Upon receipt of such information, the Plan may reconsider the Adverse Determination or Final Adverse Determination. Such reconsideration shall not delay the external review. The Plan may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within 1 business day after making the decision to end the external review, the Plan shall notify the IRO, you, and if applicable, your authorized representative of its decision to reverse the determination.

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

- Your medical records;
- Your health care provider's recommendation;
- Consulting reports from appropriate health care providers and associated records from health care providers;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by the Plan or its designated utilization review organization;
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above, for a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether and to what extent (a) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, (b) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment would be substantially increased over those of available standard health care services or treatments, or (c) the terms of coverage under your benefit program to ensure that the health care services or treatment would otherwise be covered under the terms of coverage of your benefit program.

Within 5 days after the date of receipt of the necessary information, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The IRO is not bound by any claim determinations reached prior to the submission of information to the IRO. You and your authorized representative, if applicable, will receive written notice from the Plan. 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 at 1-877-527-9431.

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 Plan;
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;
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 decision.

If the external review was a review of experimental or investigational treatments, the notice shall include the following additional information:

1. A description of your medical condition;
2. A description of the indicators relevant to whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than

not to be more beneficial to you than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

3. A description and analysis of any medical or scientific evidence considered in reaching the opinion;
4. A description and analysis of any evidence-based standards;
5. Whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration;
6. Whether medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be more beneficial to you than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
7. The written opinion of the clinical reviewer, including the reviewer's recommendation or requested health care service or treatment that should be covered and the rationale for the reviewer's recommendation.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program even if the IRO determines that the health care services being reviewed were medically appropriate.

2. Expedited 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 Illinois Managed Care Reform and Patient Rights Act; or, (c) a standard external review as set forth in the Illinois Health Care External Review 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 IRO not associated with the Plan. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you may request an expedited 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.

Notification. The Plan shall immediately notify you and your authorized representative, if applicable, in writing whether the expedited request is complete and eligible for an expedited external review. The Plan's determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director. The Director may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the Director's decision shall be in accordance with the terms of the benefit program and shall be subject to all applicable laws.

Assignment of IRO. If your request is eligible for expedited external review, the Plan shall immediately assign an IRO from the list of approved IROs; and notify you and your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Upon assignment of an IRO, the Plan or its designated utilization review organization shall, within 24 hours, provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may submit additional information in writing to the assigned IRO. If the Plan or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within 1 business day after making the decision to end the external review, the IRO shall notify the Plan, you and, if applicable, your authorized representative, of its decision to reverse the determination.

Within 2 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 the Plan. Until July 1, 2013, if you disagree with the determination of the external independent reviewer, you may contact the Illinois Department of Insurance.

The assigned IRO is not bound by any decisions or conclusions reached during the Plan's utilization review process or the Plan's internal grievance process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program if the IRO determines that the health care services being appealed were medically appropriate.

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

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

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

Karen Atwood
President

A message from

BLUE CROSS AND BLUE SHIELD

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

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

We suggest that you read this entire Certificate very carefully. We hope that any questions that you might have about your coverage will be answered here. Should you have any questions regarding the benefits of this Certificate, please contact customer service at the toll-free number on the back of your identification card.

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

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

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

Sincerely,

Maurice Smith

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BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, it is necessary to read this entire Certificate to obtain a complete description of your benefits. It is important to remember that benefits will only be provided for services or supplies that have been ordered by your Primary Care Physician (PCP) or Woman's Principal Health Care Provider (WPHCP), unless specified otherwise in this Certificate.

PHYSICIAN BENEFITS

— Your Cost for Covered Services (unless specified otherwise below)	None
— Your Cost for Outpatient Office Visits	$50 per Visit
— Your Cost for Outpatient Specialist Physician Visits	$70 per Visit
— Your Cost for Outpatient Office Visits for Periodic Health Examinations or Routine Pediatric Care	None
— Your Cost for Outpatient Office Visits for the Treatment of Mental Illness Other Than Serious Mental Illness, when not authorized by your PCP or WPHCP	50% of Provider's Charge
— Chiropractic and Osteopathic Manipulation Maximum	
— Limit on Number of Outpatient Rehabilitative Therapy Treatments	60 Treatments per Calendar Year
— Your Cost for Outpatient Office Visits for Preventive Care Services	None

HOSPITAL BENEFITS

— Your Cost for Inpatient Covered Services	$750 per Day up to 3 Days per Calendar Year
— Your Cost for the Inpatient Treatment of Mental Illness Other Than Serious Mental Illness, when not authorized by your PCP or WPHCP	50% of Provider's Charge

— Your Cost for Outpatient Surgery	$300 per Visit
— Your Cost for All Other Outpatient Covered Services	None

SUPPLEMENTAL BENEFITS

EMERGENCY CARE BENEFITS

— Your Cost for an In-Area Emergency	None, after program deductible
— Your Cost for an Out-of-Area Emergency	None, after program deductible
— Your Cost for Emergency Ambulance Transportation	None

SUBSTANCE USE DISORDER TREATMENT BENEFITS

— Your Cost for Inpatient Substance Use Disorder Treatment	$750 per Day for up to 3 Days per Calendar Year
— Your Cost for Outpatient Office Visits for Substance Use Disorder Treatment	$50 per Visit
— Your Cost for Outpatient Specialist Physician Office Visits for Substance Use Disorder Treatment	$50 per Visit

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

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

— Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Participating in the **34-Day Supply** Prescription Drug Program:

— Generic Drugs and Generic Diabetic Supplies, insulin and insulin syringes	$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
— Self-Injectable Drugs other than Insulin and Infertility Drugs	$50 per Prescription

— Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Not Participating in the **34-Day Supply** Prescription Drug Program:

— For drugs or diabetic supplies purchased within Illinois:

No benefits will be provided for drugs or diabetic supplies purchased from a Non-Participating Prescription Drug Provider.

— For drugs or diabetic supplies purchased outside Illinois:

The appropriate Copayment(s) or Coinsurance indicated above plus any difference between the Participating Provider's Charge and the Non-Participating Provider's Charge for drugs prescribed for emergency conditions.

— Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Participating in the **90-Day Supply** Prescription Drug Program:

— Generic Drugs and Generic Diabetic Supplies, insulin and insulin syringes	$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
— Self-Injectable Drugs other than Insulin and Infertility Drugs	$50 per Prescription

— Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Not Participating in the **90-Day Supply** Prescription Drug Program:

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

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ELIGIBILITY

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

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

— Meet the definition of an Eligible Person as specified in the Group Policy;
— Have applied for this coverage;
— Have received a Blue Cross and Blue Shield identification card;
— Live within the Plan's service area. (Contact your Group or Member Services at 1-800-892-2803 for information regarding service area.);
— Reside, live or work in the geographic network service area served by Blue Cross and Blue Shield for this Certificate of coverage. You may call customer service at the number shown on the back of your identification card to determine if you are in the network service area or log on to the Web site at *www.bcbsil.com* and;
— If Medicare eligible, have both Part A and B coverage.

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

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

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

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

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

APPLYING FOR COVERAGE

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

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

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

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

You may enroll in or change coverage for yourself and/or your eligible spouse and/or dependents during one of the following enrollment periods. Your and/or your eligible spouse and/or dependents' effective date will be determined by the Plan depending upon the date your application is received and other determining factors.

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

Annual Open Enrollment Periods/Effective Date of Coverage

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

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

SPECIAL ENROLLMENT PERIODS

Special Enrollment Periods/Effective Dates of Coverage

Special enrollment periods have been designated during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union and/or dependents. You must apply for or request a change in coverage within 31 days from the date of a special enrollment event, except as otherwise provided below, in order to qualify for the changes described in this Special Enrollment Periods/Effective Dates of Coverage section.

Special Enrollment Events:

a. You gain or lose a dependent or become a dependent through marriage or becoming a party to a Civil Union. New coverage for you and/or your eligible spouse, party to a Civil Union and/or dependents will be effective on the date of the qualifying event, so long as you apply 31 days from the qualifying event date.

b. You gain or lose a dependent through birth, placement of a foster child, adoption or placement of adoption or court-ordered dependent coverage. New coverage for you and/or your eligible spouse, party to a Civil Union, and/or dependents will be effective on the date of the birth, placement of a foster child, adoption, or placement of adoption. However, the effective date for court-ordered eligible child coverage will be determined by the Plan in accordance with the provisions of the court-order.

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

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

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

Other Special Enrollment Events/Effective Dates of Coverage:

You must apply for or request a change in coverage within 31 days from the date of the below other special enrollment events in order to qualify for the changes described in this Other Special Enrollment Events/Effective Dates of Coverage section.

1. Loss of eligibility as a result of:

   - Legal separation, divorce, or dissolution of a Civil Union;
   - Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent child under this Certificate);
   - Death of an Employee;
   - Termination of employment, reduction in the number of hours of employment.

2. Loss of coverage through an HMO in the individual market because you and/or your eligible spouse, party to a Civil Union and/or dependents no longer reside, live or work in the network service area.

3. Loss of coverage through an HMO, or other arrangement, in the group market because you and/or your eligible spouse, party to a Civil Union and/or dependents no longer reside, live or work in the network service area, and

no other coverage is available to you and/or your eligible spouse, party to a Civil Union and/or dependents.

4. You incur a claim that would meet or exceed a lifetime limit on all benefits.
5. Loss of coverage due to a plan no longer offering benefits to the class of similarly situated individuals that include you.
6. Your Employer ceases to contribute towards your or your dependent's coverage (excluding COBRA continuation coverage).
7. COBRA continuation coverage is exhausted.

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

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

NOTIFICATION OF ELIGIBILITY CHANGES

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

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

Under Family Coverage, your health care expenses and those of your enrolled spouse and your (and/or your spouse's) enrolled children who are under the limiting age specified in the BENEFIT HIGHLIGHTS section will be covered. All of the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise.

"Child(ren)" used hereafter in this Certificate, means a natural child(ren), a stepchild(ren), adopted child(ren), foster child(ren), a child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those

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

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

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

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

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

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

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

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

MEDICARE ELIGIBLE COVERED PERSONS

A series of federal laws collectively referred to as the ‘‘Medicare Secondary Payer’’ (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children. Reference to spouse under this section do not include a party to a Civil Union with the Eligible Person or their children.

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

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

2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

Please see your employer or Group Administrator if you have any questions regarding the ESRD Primary Period or any other provisions of the MSP laws and their application to you, your spouse or your dependents.

Your MSP Responsibilities

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

YOUR IDENTIFICATION CARD

You will receive an identification (ID) card from the Plan. Your ID card contains your identification number, the name of the Participating IPA/Participating Medical Group that you have selected and the phone number to call in an emergency. Always carry your ID card with you. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost or stolen card, contact customer service or go to *www.bcbsil.com* and get a temporary card online.

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

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

— Marriage.

— Birth, adoption or placement for adoption of a child.

— Obtaining legal guardianship of a child.

— Becoming party to a Civil Union.

— Loss of eligibility for other health coverage for you or your dependent if:

a. The other coverage was in effect when you were first eligible to enroll for this coverage;

b. The other coverage is not terminating for cause (such as failure to pay premiums or mailing a fraudulent claim); and

c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

This includes, but is not limited to, loss of coverage due to:

a. Legal separation, divorce, dissolution of a Civil Union, cessation of dependent status, death of an employee, termination of employment, or reduction in number of hours of employment;

b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;

c. Reaching a lifetime limit on all benefits in another group health plan;

d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;

e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss eligibility; or

f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

— Termination of employer contributions towards 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 dependent(s) will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

— Marriage.

— Birth, adoption or placement for adoption of a child.

— Obtaining legal guardianship of a child.

— Becoming party to a Civil Union.

— Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.

— Termination of employer contributions towards your or your dependent's other coverage.

— Exhaustion of COBRA continuation or state continuation coverage.

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

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

— Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or

— You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

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

LATE APPLICANTS

If you do not apply for Family Coverage or to add dependents within the allotted time, you will have to wait until your Group's annual open enrollment period to do so. Your Family Coverage or the coverage for your additional dependents will then be effective on the first day of the month following the open enrollment period. Benefits will not be provided for any treatment of an illness or injury to a newborn child unless you have Family Coverage. (Remember, you must add the newborn child within 31 days of the date of birth.)

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

You can apply to change from Family to Individual Coverage at any time. Your Group Administrator will give you the application and tell you the date that the change will be effective. Premiums will be adjusted accordingly.

TERMINATION OF COVERAGE

If the Plan terminates your coverage under this Certificate for any reason, the Plan will provide you with a notice of termination of coverage that includes the termination effective date and the reason for termination at least 30 days prior to the last day of coverage, except as otherwise provided in this Certificate.

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

a. The termination date specified by you, if you provide reasonable notice.

b. When the Plan does not receive the full amount of the premium payment or other charge or amount on time or when there is a bank draft

failure of premiums for your and/or your eligible spouse, party to a Civil Union and/or dependents' coverage and the grace period, if any, has been exhausted.

c. You no longer live, reside or work in the Plan's service area or live, reside or work in the network service area.

d. Your coverage has been rescinded.

e. In the case of intentional fraud or material misrepresentation.

f. You no longer meet the previously stated description of an Eligible Person.

g. The entire coverage of your Group terminates.

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

Termination of a Dependent's Coverage

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

WHO IS NOT ELIGIBLE

a. Non-citizens or non-nationals of the United States, or individuals who are non-citizens and not lawfully present in the United States, and are not reasonably expected to be a citizen, national, or a non-citizen, who is not lawfully present for the entire period for which open enrollment is sought. Please see the Initial and Annual Open Enrollment Periods/ Effective Date of Coverage section of this Certificate.

b. Incarcerated individuals, other than incarcerated individuals pending disposition of charges.

c. Individuals that do not live, reside or work in the network service area.

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

This section "WHO IS NOT ELIGIBLE" is subject to change by the Plan and/or applicable law, as appropriate.

Extension of Benefits in Case of Discontinuance of Coverage

If you are Totally Disabled at the time your entire Group terminates, benefits will be provided for (and limited to) the Covered Services described in this Certificate which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's policy whether due to the absence of coverage in the policy or lack of required Creditable Coverage for a preexisting

condition. Benefits will be provided for a period of no more than 12 months from the date of termination. These benefits are subject to all of the terms and conditions of this Certificate including, but not limited to, the requirements regarding Primary Care Physician referral. It is your responsibility to notify the Plan, and to provide, when requested by the Plan, written documentation of your disability. This extension of benefits does not apply to the benefits provided in the following Benefit Section(s) of this Certificate:

- Outpatient Prescription Drug Program Benefits

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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 or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation 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 properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

COVERAGE AFTER TERMINATION (Illinois State Laws)

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

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

ARTICLE A: **Continuation 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, Physician and Supplemental coverage provided under this Certificate for himself/herself and his/her eligible dependents (if he/she had Family Coverage on the date of termination). However, this continuation 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 or (b) you have coverage under any other health care program which provides group hospital, surgical or medical coverage and under which you were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility, or (c) you decide to become a member of the Plan on a "direct pay" basis.
3. If you decide to become a member of the Plan 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, you may exercise the Conversion Privilege explained in the ELIGIBILITY section of this Certificate.
4. 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.
5. If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by the Plan for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to the Plan (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.
6. Continuation of coverage under this Certificate will end on the date you become eligible for Medicare, become a member of the Plan on a "direct pay" basis or become covered under another health care program (which you did

not have on the date of your termination or reduction in hours below the minimum required for eligibility) which provides group hospital, surgical or medical coverage. However, your continuation of coverage under this Certificate will also end on the first to occur of the following:

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

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

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

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

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

   b. notice of the amount of monthly charges to be paid by you for such continuation 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 the Plan.

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

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

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

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

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

   Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate your continuation benefits and the right to continuation 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 the Plan 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 the Plan of the death of the Eligible Person or of the dependent child reaching the limiting age, as well as notice of the dependent child's address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. The Plan's notice to you will include the following:

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

   b. notice of the amount of monthly charges to be paid by you for such continuation 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 the Plan.

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

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

6. The monthly charge will be computed as follows:

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

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

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

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

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

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

Continuation of Coverage

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

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

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision **and CONTINUATION COVERAGE RIGHTS UNDER COBRA**, 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.

If you are a dependent who is a party to a Civil Union or their child and you lose coverage under this Certificate, the options available to a spouse or to a dependent child are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision of this Certificate.

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union partnership with the Eligible Person terminates. Your Civil Union 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.

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 below.

CONVERSION

In addition to the option of continuing your Group coverage after termination, you have the option of converting your Group coverage to direct-payment coverage. This option, conversion privilege, is explained below.

If you choose to convert your Group coverage to direct-payment coverage, you may not, at a later date, select the continuation of group coverage option. However, the conversion privilege will be available when the continuation of coverage period ends.

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 canceled this coverage and replaced it with other coverage. Here is what to do:

— Tell the Plan or your Group Administrator that you wish to continue your coverage and you will be provided with the necessary application.

— Send the application to the Plan within 31 days of the date that your coverage is terminated.

— Send the application and first premium to the Plan within 31 days of the date that you leave your Group or within 15 days after you have been given writ-

ten 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 the Plan on an individual "direct-payment" basis. This coverage will be effective from the date that your Group coverage terminates as long as the premiums charged for the direct pay coverage are paid when due.

The converted coverage may require copayments and/or deductibles that are different from those of this Certificate. The converted coverage will provide, at minimum, benefits for basic health care services as defined in the HMO Act.

The Plan is not required to offer conversion coverage to you if you no longer live within the service area of a Participating IPA or Participating Medical Group. However, if you have similar benefits under a group arrangement that does not cover pre-existing conditions, and you have a pre-existing condition, you can continue conversion coverage until your pre-existing condition is covered under that group arrangement.

Conversion coverage is not available when your Group terminates its coverage under this Certificate and replaces it with other coverage or when your coverage has been terminated for: failure to pay a required premium or charge; fraud or material misrepresentation in enrollment or in the use of services or facilities.

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.

YOUR PRIMARY CARE PHYSICIAN

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

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

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

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

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

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

The only time that you can receive benefits for services not ordered by your Primary Care Physician or Woman's Principal Health Care Provider is when you are receiving either emergency care, treatment for Mental Illness other than Serious Mental Illness or routine vision examinations. These benefits are explained in detail in the EMERGENCY CARE BENEFITS, HOSPITAL BENEFITS sections

and, for routine vision examinations or Mental Illness other than Serious Mental Illness, in the PHYSICIAN BENEFITS section of this Certificate. It is important that you understand the provisions of those sections.

PLEASE NOTE, BENEFITS WILL NOT BE PROVIDED FOR SERVICES OR SUPPLIES THAT ARE NOT LISTED AS COVERED SERVICES IN THIS CERTIFICATE, EVEN IF THEY HAVE BEEN ORDERED BY YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER.

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

You may change your choice of Primary Care Physician or Woman's Principal Health Care Provider to one of the other Physicians in your Participating IPA or Participating Medical Group by notifying your Participating IPA/Participating Medical Group of your desire to change. Contact your Participating IPA/Participating Medical Group, your Primary Care Physician or Woman's Principal Health Care Provider or the Plan to obtain a list of providers with whom your Primary Care Physician and/or Woman's Principal Health Care Provider have a referral arrangement.

Changing Your Participating IPA/Participating Medical Group

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

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

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

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

You may select a Participating IPA/Participating Medical Group for your newborn child. Your newborn will remain with the mother's Participating IPA/Participating Medical Group/Woman's Principal Health Care Provider, if one has been selected, from the date of birth to the end of the month in which he/she is discharged from the Hospital. Your newborn may be added to the selected Partici-

pating IPA/Participating Medical Group on the first day of the month following discharge from the Hospital.

Transition of Care Benefits

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

If you are a current HMO enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy and your Primary Care Physician or Woman's Principal Health Care Provider leaves the Plan's network, you may request the option of transition of care benefits. You must submit a written request to the Plan for transition of care benefits within 30 business days after receiving notification of your Primary Care Physician or Woman's Principal Health Care Provider's termination.

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

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

PHYSICIAN BENEFITS

This section of your Certificate explains what your benefits are when you receive care from a Physician.

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

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

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

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

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

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

The following services are also part of your surgical benefits:

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

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

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

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

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

Medical Care

Benefits will be provided for Medical Care rendered to you:

— when you are an Inpatient in a Hospital or Skilled Nursing Facility;

— when you are a patient in a Home Health Care Program; or

— on an Outpatient basis in your Physician's office or your home.

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

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

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

Mammograms — Benefits will be provided for mammograms for all women. A 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 mammograms will be provided as follows:

— one baseline mammogram

— an annual mammogram

Benefits for mammograms will be provided for women who have a family history of breast cancer or other risk factors at the age and intervals as often as your Primary Care Physician or Woman's Principal Health Care Provider finds necessary.

If a mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening of an entire breast or breasts as determined by your Primary Care Physician or Woman's Principal Health Care Provider.

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

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

Health Care Provider, following generally accepted medical practice, finds necessary.

Covered Services include, but are not limited to:

— clinical breast examinations;

— routine cervical smears or Pap smears;

— routine prostate-specific antigen tests and digital rectal examinations;

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

— ovarian cancer screening — using CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination.

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

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

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

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

Allergy Testing and Treatment

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

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

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

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

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

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

Chemotherapy — that is, the treatment of malignancies with drugs.

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

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

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

— psychiatric care, including diagnostic services;

— psychological assessment and treatment;

— habilitative or rehabilitative treatment;

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

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

1. a Physician has diagnosed the Congenital, Genetic or Early Acquired Disorder; and
2. treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker or Psychologist upon the referral of your Primary Care Physician or Woman's Principal Health Care Provider; and

3. treatment must be medically necessary and therapeutic and not Investigational.

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

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

Hearing Screening — when done to determine the need for hearing correction. Benefits will be provided for hearing aids for children under age 19 and will be limited to two every 36 months.

Diabetes Self-Management Training and Education — benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will also be provided for education programs that allow you to maintain a hemoglobin A1c level within the range identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

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

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

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

Dental Accident Care — that is, dental services rendered by a Dentist or Physician which are required as the result of an accidental injury. However, these services are covered only if the injury is to sound natural teeth. A sound natural tooth is any tooth that has an intact root or is part of a permanent bridge.

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

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

Outpatient Contraceptive Services — Benefits will be provided for 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.

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

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

Infertility Treatment

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

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

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

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

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

— you have not undergone four (4) completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

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

The maximum number of completed oocyte retrievals you are eligible for 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.

Benefits will not be provided for the following:

1. Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of "infertility" as stated above.
2. 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.
3. Selected termination of an embryo in cases where the mother's life is not in danger.
4. Cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
5. Non-medical costs of an egg or sperm donor.
6. Travel costs for travel within 100 miles of the covered person's home or which is not medically necessary or which is not required by the Plan.
7. Infertility treatments which are determined to be Investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology.
8. Infertility treatment rendered to your dependents under the age of 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 Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

Mastectomy Related Services

Benefits will be provided for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) post mastectomy care for inpatient treatment for a length of time determined by the attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evi-

dence and patient evaluation, and a follow-up Physician office visit or in-home nurse visit within forty-eight (48) hours after discharge; and 4) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; 5) the removal of breast implants when the removal of the implants is a medically necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury are not considered cosmetic Surgery.

Maternity Services

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

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

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

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

Your coverage also includes benefits for elective abortions, if legal where performed, limited to a lifetime maximum of two abortions.

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, the Plan will neither provide benefits for such care nor coordinate benefits with any other health care coverage that you may have.

URGENT CARE

This benefit provides medically necessary outpatient care if you are outside the Plan's service area and experience an unexpected illness or injury that would not be considered an Emergency Condition, but which should be treated before re-

turning home. Services usually are provided at a Physician's office. If you require such Urgent Care, you should contact 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians and Hospitals that you can contact to arrange an appointment for Urgent Care.

Payment for Urgent Care Treatment

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

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

FOLLOW-UP CARE

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

Payment for Follow-Up Care Treatment

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

COST TO YOU FOR PHYSICIAN SERVICES

The Covered Services of this benefit section are covered in full, with no cost to you, except as follows:

Benefits for all Outpatient office visits, except for Surgery or maternity services after the first pre-natal visit, are subject to a Copayment of $50 per visit, unless otherwise specified in this Certificate, and then will be paid in full when such services are received from a:

— Physician

— Physician Assistant

— Certified Nurse Midwife

— Certified Nurse Practitioner

— Certified Registered Nurse Anesthetist

— Certified Clinical Nurse Specialist

— Marriage and Family Therapist

Benefits for Outpatient visits to a Specialist Physician's office are subject to a Co-payment of $70 per visit and then will be paid in full.

Benefits for Outpatient office visits for the treatment of Mental Illness other than Serious Mental Illness will be provided at 50% of Provider's Charge when such treatment is not authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

HOSPITAL BENEFITS

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

Remember, to receive benefits for Covered Services, (except for Mental Illness other than Serious Mental Illness), they must be ordered or approved by your Primary Care Physician or Woman's Principal Health Care Provider.

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

COVERED SERVICES

Inpatient Benefits

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

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

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

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

Number of Inpatient Days

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

Outpatient Benefits

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

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

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

Special Programs

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

1. **Coordinated Home Care Program**
2. **Pre-Admission Testing** — This is a program in which preoperative tests are given to you as an Outpatient in a Hospital to prepare you for Surgery that you are scheduled to have as an Inpatient.
3. **Partial Hospitalization Treatment Program** — This is a therapeutic treatment program in a Hospital for patients with Mental Illness.
4. **Intensive Outpatient Treatment Program** — This is a Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorders or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorders. 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 Disorder conditions. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions, 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.

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

— psychiatric care, including diagnostic services;

— psychological assessment and treatment;

— habilitative or rehabilitative treatment;

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

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

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

Surgical Implants

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

Maternity Services

Your benefits for services rendered in connection with pregnancy are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. In addition to all of the previously described Covered Services, routine Inpatient nursery charges for the newborn child are covered, even under Individual Coverage. (If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, that care will be covered from the moment of birth up to the first 31

days, thereafter, you must add the newborn child to your Family Coverage. Premiums will be adjusted accordingly.

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

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

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

Your coverage also includes benefits for elective abortions, if legal where performed, limited to a lifetime maximum of two abortions.

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, the Plan will neither provide benefits for such care nor coordinate benefits with any other health care coverage that you may have.

URGENT CARE

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

Payment for Urgent Care Treatment

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

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

mary Care Physician or Woman's Principal Health Care Provider as soon as possible if Inpatient Hospital care is required.

FOLLOW-UP CARE

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

Payment for Follow-Up Care Treatment

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

BENEFIT PAYMENT FOR HOSPITAL SERVICES

When you are admitted as an Inpatient to a Hospital, Skilled Nursing Facility or Residential Treatment Center, you are responsible for paying a Copayment of $750 per day up to a maximum of 3 days per calendar year. If you have paid any Inpatient Substance Use Disorder Treatment Copayments as described in the SUBSTANCE USE DISORDER TREATMENT BENEFITS section of this Certificate in the same calendar year, those Copayments can be used to satisfy the 3 day maximum. After the Copayment, benefits for Covered Services will be paid at 100% of the Provider's Charge, except as specifically mentioned below.

50% of the Provider's Charge will be paid when you receive Covered Services for the Inpatient treatment of Mental Illness other than Serious Mental Illness, when not authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

Benefits for Outpatient Surgery are subject to a Copayment of $300 per visit and then will be paid in full.

SUPPLEMENTAL BENEFITS

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

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

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

- **Blood and Blood Components**
- **Medical and Surgical Dressings, Supplies, Casts and Splints**
- **Oxygen and its administration**
- **Naprapathic Service** — Benefits will be provided for Naprapathic Services when rendered by a Naprapath.
- **Prosthetic Devices** — benefits will be provided for prosthetic devices, special appliances and surgical implants required for an illness or injury when:

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

  Adjustments, repairs and replacements of these devices, appliances and implants are also covered when required because of wear or a change in your condition. Benefits will not be provided for dental appliances or hearing aids, except for bone anchored hearing aids (osseointegrated auditory implants), or for replacement of cataract lenses unless a prescription change is required.
- **Orthotic Devices** — that is, a supportive device for the body or a part of the body, head, neck or extremities including, but not limited to leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition as determined by your Primary Care Physician or Woman's Principal Health Care Provider.
- **Durable Medical Equipment** — that is, durable equipment which primarily serves a medical purpose, is appropriate for home use and generally is not useful in the absence of injury or disease. Benefits will be provided for the rental of a piece of equipment (not to exceed the total cost of equipment) or purchase of the equipment. Durable medical equipment must be rented or purchased from a Plan contracting durable medical equipment provider. Contact your Participating IPA/Participating Medical Group prior to purchasing or renting such equipment.

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

YOUR COST FOR COVERED SERVICES

EMERGENCY CARE BENEFITS

This section of your Certificate explains your emergency care benefits.

Notwithstanding anything in your Certificate to the contrary, for emergency care benefits rendered by Providers who are not part of your HMO's network or otherwise contracted with your HMO, the Provider's Charge shall be the amount negotiated with Providers for emergency care benefits furnished.

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

IN-AREA TREATMENT OF AN EMERGENCY

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

Although you may go directly to the nearest Hospital emergency room to obtain treatment for an Emergency Condition, we recommend that you contact your Primary Care Physician or Woman's Principal Health Care Provider first if you are in your Participating IPA's/Participating Medical Group's treatment area. Benefits will be provided for the Hospital and Physician services that he/she authorizes.

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

Payment for In-Area Emergency Treatment

Benefits for emergency treatment received in your Participating IPA's/Participating Medical Group's treatment area will be paid at 100% of the Provider's Charge, after you have satisfied your program deductible.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate.

OUT-OF-AREA TREATMENT OF AN EMERGENCY

If you are more than 30 miles away from your Participating IPA/Participating Medical Group and need to obtain treatment for an Emergency Condition, benefits will be provided for the Hospital and Physician services that you receive. Benefits are available for the initial treatment of the emergency and for related follow-up care but only if it is not reasonable for you to obtain the follow-up care from your Primary Care Physician or Woman's Principal Health Care Provider. If

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

Payment for Out-of-Area Emergency Treatment

Benefits for emergency treatment received outside of your Participating IPA's/Participating Medical Group's treatment area will be paid at 100% of the Provider's Charge, after you have satisfied your program deductible.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate.

EMERGENCY AMBULANCE BENEFITS

Benefits for emergency ambulance transportation are available when:

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

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

100% of the Provider's Charge will be paid for emergency ambulance transportation.

SUBSTANCE USE DISORDER TREATMENT BENEFITS

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

Covered Services are the same as those provided for any other condition, as specified in the other benefit sections of this Certificate. In addition, benefits are available for Covered Services provided by a Substance Use Disorder Treatment Facility or a Residential Treatment Center in the BlueAdvantage Substance Use Disorder Network. To obtain benefits for Substance Use Disorder Treatment, they must be authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

INPATIENT BENEFITS

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

When you are admitted as an Inpatient to a Hospital, Substance Use Disorder Treatment Facility or Residential Treatment Center, you are responsible for paying a Copayment of $750 per day up to a maximum of 3 days per calendar year. If you have paid any Inpatient Hospital Benefits Copayments as described in the HOSPITAL BENEFITS section of this Certificate in the same calendar year, those Copayments can be used to satisfy the 3 day maximum. After the Copayment, benefits for Covered Services will be paid at 100% of the Provider's Charge.

COST TO YOU FOR OUTPATIENT BENEFITS

Benefits for Outpatient office visits for Substance Use Disorder Treatment are subject to a $50 Copayment per visit and then will be paid at 100% of the Provider's Charge.

In addition, benefits for Outpatient Substance Use Disorder Treatment visits to a Specialist Physician's office are subject to a Copayment of $50 per visit and then will be paid in full.

Detoxification

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

AWAY FROM HOME CARE® BENEFITS

The Plan is a participant in a nation-wide network of Blue Cross and Blue Shield-affiliated plans. This enables the Plan to provide you with Guest Membership benefits when you are outside the service-area of the Plan.

GUEST MEMBERSHIP

If you will be living outside of the Home Plan's service area for more than 90 days, but will maintain a permanent residence within the Plan's service area, the Home Plan will establish a Guest Membership for you with a Host Plan serving the area in which you will be staying.

Under this arrangement, the Plan is referred to as the "**Home Plan**". The Blue Cross and Blue Shield plan in the area in which you are temporarily residing is called the "**Host Plan**".

This would apply for members who are:

1. On an extended work assignment in another state for a period of 90 days to six months;
2. Long-term travelers who will be out of the Home Plan's service area for 90 days to six months;
3. Eligible children at school out-of-state for periods of 90 days to one year; or
4. Eligible dependents living away from the employee's household in another state for periods of 90 days to one year.

Guest memberships for eligible children who are at school out-of-state or for eligible dependents who live in another state may be renewed at the end of the period.

You will select a Primary Care Physician in your Guest Membership's area, just as you have within your home area. This Primary Care Physician will be responsible for coordinating all of your health care needs.

You may contact your Employer or Group Administrator to initiate the establishment of a Guest Membership, or you may call Member Services directly at 1-800-892-2803.

Benefits for Guest Membership

Each Host Plan establishes its own Guest Membership benefits. Consequently, your Guest Membership Copayment may differ from your Home Plan Copayments. However, all Basic Services will be covered. The Host Plan will provide you with an explanation of your benefits and Copayments.

HUMAN ORGAN TRANSPLANT BENEFITS

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

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

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

— If both the donor and recipient have coverage with the Plan, each will have his/her benefits paid by his or her own program.

— If you are the recipient and your donor does not have coverage from any other source, the benefits of this Certificate will be provided for both you and your donor. The benefits provided for your donor will be charged against your coverage under this Certificate.

— If you are the donor and coverage is not available to you from any other source, the benefits of this Certificate will be provided for you. However, benefits will not be provided for the recipient.

Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Primary Care Physician or Woman's Principal Health Care Provider, and you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and 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 50 miles from the Hospital where the transplant will be performed.

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

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

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

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

HOSPICE CARE BENEFITS

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

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

The following services are covered under the Hospice Care Program:

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

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

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

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

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

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

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

Although you can go to the Pharmacy of your choice, your benefits for drugs and supplies will be greater when you obtain them from a Participating Pharmacy. You can visit the Plan's 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 — WHAT IS NOT COVERED sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

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

BRAND NAME DRUG.....means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from Generic to 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.

COINSURANCE AMOUNT.....means the percentage amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or non-Participating Pharmacy.

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

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

(ii) the agreed upon cost between Participating Pharmacy and the Plan or the entity chosen by the Plan 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. This 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, the Plan utilizes the generic/brand status assigned by a nationally recognized provider of drug product database 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. This *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, mail order Pharmacy or specialty drug Pharmacy which has not entered into a written agreement with the Plan to provide pharmaceutical services to you or an entity which has not been chosen by the Plan to administer its prescription drug program services to you at the time you receive the services.

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

PHARMACY.....means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription 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 high cost oral medications. 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 the Plan or the entity chosen by the Plan to administer its prescription drug program to provide Specialty Drugs to you.

ABOUT YOUR BENEFITS

Formulary Drug List

Formulary drugs are selected by the Plan based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Plan. The committee considers drugs regulated by the FDA for inclusion on the *Formulary Drug List*. 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. The Plan 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.

PRIOR AUTHORIZATION/STEP THERAPY REQUIREMENT

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, you will be required to obtain authorization from the Plan in order to receive benefits. Medications included in this program are subject to change and other medications for other conditions may be added to the program. Although you may currently be on therapy, your Claim may need to be reviewed to see if the criteria for coverage of further treatment 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.

The Plan's prescription drug administrator will send a questionnaire to your Physician upon your or your Pharmacy's request. The questionnaire must be returned to the prescription drug administrator who will review the questionnaire and determine whether the reason for the prescription meets the criteria for medically necessary care. You and your Physician will be notified of the prescription drug administrator's determination. 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 a mail order Pharmacy.

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

Day Supply

The Plan has the right to determine the day supply. Payment for benefits covered under this benefit section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Specialty Drugs are limited to a 30 day supply.

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 substantially accepted peer-reviewed medical literature for treatment of the indication for which the drug is prescribed.

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, the Plan 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, and as determined by the Plan.

Diabetic Supplies for Treatment of Diabetes

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

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

Compound Drugs

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

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

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

(iii) The primary active ingredient is a Covered Drug under this benefit section.

Compound Drugs will be provided at the Non-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.

90-Day Supply Prescription Drug Program

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

Some drugs may not be available through the 90-Day Supply Prescription Drug Program. If you have any questions about the 90-Day Supply Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the mail order form, you may access the Web site at *www.bcbsil.com* or call the Customer Service toll-free number on your identification card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

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

BENEFIT PAYMENT FOR PRESCRIPTION DRUGS

34-Day Supply Prescription Drug Program

Benefit payment for the 34-day supply prescription drug program

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

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

One prescription means up to a 34 consecutive day supply for most medications. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs, larger quantities may be obtained through the 90-day supply prescription drug program. Specific information on these maintenance drugs can be obtained from a Prescription Drug Provider participating in the 90-day supply prescription drug program or the Plan. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

No benefits will be provided when you purchase drugs or diabetic supplies from a Non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider) in Illinois. However, if the Non-Participating

Prescription Drug Provider is located outside of Illinois, then benefits for drugs purchased for emergency conditions will be provided and you will be responsible for the specified Copayment amount shown in the Benefit Highlights section of this Certificate. You will be charged the Copayment amount for each prescription.

90-Day Supply Prescription Drug Program

Benefit payment for the 90-day supply prescription drug program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs and diabetic supplies purchased from a Participating Prescription Drug Provider (which may include retail or mail order pharmacies) participating in the 90-day supply prescription drug program. You will not be charged any amount other than the Copayment amount, specified in the Benefit Highlights section of this Certificate. The Copayment amounts are shown in the Benefit Highlights section of this Certificate.

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

You can obtain an order form for the 90-day supply prescription drug program from your Group or from the Plan.

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) injection in the home setting, except as specifically mentioned in this Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
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. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
17. 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.
18. Athletic performance enhancement drugs.
19. Allergy serum and allergy testing materials.
20. Injectable drugs, except those determined by the Plan to be self-administered.

21. Some equivalent drugs manufactured under multiple brand names. The Plan 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.

PRE-ADMISSION CERTIFICATION AND CONCURRENT REVIEW

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

PRE-ADMISSION CERTIFICATION

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

CONCURRENT REVIEW

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

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

EXCLUSIONS — WHAT IS NOT COVERED

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

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

— Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated.

— Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received, except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.

— Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental/Investigational in nature. This exclusion however does not apply to a) the cost of routine patient care associated with Investigational treatment if you are a qualified individual participating in an Approved Clinical Trial program or b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

— Custodial Care Service.

— Long Term Care Services.

— Respite Care Services, except as specifically mentioned under Hospice Care Benefits.

— Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. 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).

— Special education therapy such as music therapy or recreational therapy, except as specifically provided for in this Certificate.

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

— Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.

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

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

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

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

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

— Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements, except as stated in this Certificate.

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

— Hypnotism.

— Inpatient and Outpatient Private Duty Nursing Service.

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

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

— Maintenance Care.

— Self-management training, education and medical nutrition therapy, except as specifically stated in this Certificate.

— Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.

— Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in this Certificate.

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

— Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

— Services or supplies rendered for human organ or tissue transplants except as specifically provided for in this Certificate.

— Wigs (also referred to as cranial prostheses).

— Services or supplies rendered for infertility treatment except as specifically provided for in this Certificate.

— Eyeglasses, contact lenses or hearing aids, except as specifically provided for this Certificate.

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

— Any services and/or supplies provided to you outside the United States, unless they are received for an Emergency condition, not withstanding any provision in the Certificate to the contrary.

COORDINATION OF BENEFITS

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

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

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

In addition to the Definitions Section of this Certificate, the following definitions apply to this section:

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

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

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

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

(i) Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

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

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

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION

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

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

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

1. Non-Dependent or Dependent

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

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

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

2. Dependent Child if Parents not Separated or Divorced

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

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

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

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

3. Dependent Child if Parents Separated or Divorced

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

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

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

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

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

4. Dependent Child if Parents Share Joint Custody

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

5. Young Adults as a Dependent

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

6. Active or Inactive Employee

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

7. Continuation Coverage

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

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

   b. Second, the benefits under the continuation coverage.

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

8. Length of Coverage

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

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

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

The foregoing not withstanding, you will only be responsible for any applicable Copayments, deductibles and/or Coinsurance as described in this Certificate.

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

ADDITIONAL BENEFITS — SAVINGS

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

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

HOW TO FILE A CLAIM

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

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

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

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

Mail all of that information to:

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

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

If you have any questions about a Claim, call **Member Services at 1-800-892-2803.**

FILING OUTPATIENT PRESCRIPTION DRUG PROGRAM CLAIMS

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

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

Blue Cross and Blue Shield of Illinois
P. O. Box 64812
St. Paul, MN 55164-0812

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.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

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

If a Claim Is Denied or Not Paid in Full

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

a. The reasons for determination;

b. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;

c. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.

e. An explanation of the Plan's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Sec-

tion 502(a) of ERISA following a final denial on internal review/appeal;

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

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

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

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

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

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

l. Contact information for applicable office of health insurance consumer assistance or ombudsman.

INQUIRIES AND COMPLAINTS

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

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

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

- Claims
- Quality of care

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

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

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

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

Timing of Required Notices and Extensions

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

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

b. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

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

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Plan must notify you within:	**24 hours****
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Plan within:	**48 hours after receiving notice**
The Plan must notify you of the Claim determination (whether adverse or not):	

Type of Notice or Extension	Timing
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed Claim (if the initial Claim is incomplete), within:	**48 hours**

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

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

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, the Plan must notify you within:	**5 days***
If your Claim is incomplete, the Plan must notify you within:	**15 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Plan within:	**45 days after receiving notice**
The Plan must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete, within:	**15 days****
after receiving the completed Claim (if the initial Claim is incomplete), within:	**30 days**
If you require post-stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

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

** This period may be extended one time by the Plan for up to 15 days, provided that the Plan both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Post-Service Claims

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

* This period may be extended one time by the Plan for up to 15 days, provided that the Plan both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Concurrent Care

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

CLAIM APPEAL PROCEDURES

Claim Appeal Procedures – Definitions

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

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

An **"Adverse Determination"** means:

a. a determination by the Plan or its designated utilization review organization that, based upon the information provided, a request for a benefit under the

Plan's health benefit plan upon application of any utilization review technique does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or it is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

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

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

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

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, Blue Cross and Blue Shield will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

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

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by the Plan in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative

Form, you or your representative may call the Plan at the number on the back of your identification card.

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

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Plan to request a Claim review. The Plan will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-800-538-8833 or send your request to:

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

- In support of your claim review, you have the option of presenting evidence and testimony to the Plan. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

  The Plan 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 rationale 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 in part on a medical judgement, the appeal will be conducted by individuals associated with the Plan and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Plan.

Timing of Non-Urgent Appeal Determinations

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

The Plan will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 15 business days after receipt of all required information (if the appeal is related to health care services and not related to administrative matters or Complaints) or 30 days after the appeal has been received by the Plan, whichever is sooner.

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

Notice of Appeal Determination

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

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

a. The reasons for the determination;

b. A reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;

c. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

d. An explanation of the Plan's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal appeal;

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

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

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

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

i. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;

j. A description of the standard that was used in denying the Claim and a discussion of the decision; and

k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

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

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

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

The Illinois Department of Insurance can be contacted at:

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

or

Illinois Department of Insurance
Consumer Division
122 South Michigan Avenue, 19th Floor
Chicago, Illinois 60603

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

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the the Plan Headquarters at 1-800-538-8833. The Plan's offices are open from 8:45 a.m. To 4:45 p.m., Monday through Friday.

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

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9432, or call the number on the back of your identification card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INDEPENDENT EXTERNAL REVIEW

You or your authorized representative may make a request for a standard external review or expedited external review of an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

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

1. **Standard External Review**

   You or your authorized representative must submit a written request for a standard external independent review to the Director of the Illinois Department of Insurance ("Director") within 4 months of receiving an Adverse Determination or Final Adverse Determination. You may submit additional information or documentation to support your request for the health care services. Within one business day after the date of receipt of the request, the Director will send a copy of the request to the Plan.

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

      - You were a covered person at the time health care service was requested or provided;
      - The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this benefit program, but the Plan has determined that the health care service is not covered;
      - You have exhausted the Plan's internal appeal process, unless you are not required to exhaust the Plan's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and
      - You have provided all the information and forms required to process an external review.

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

      - Standard health care services or treatments have not been effective in improving your condition;
      - Standard health care services or treatments are not medically appropriate for you; or

- There is no available standard health care services or treatment covered by the Plan that is more beneficial than the recommended or requested service or treatment.
- In addition, a) your health care provider has certified in writing that the health care service or treatment is likely to be more beneficial to you, in the opinion of your health care provider, than any available standard health care services or treatments; or b) your health care provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.

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

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

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

external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by the Plan or designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the external review. Within one business day after making the decision to end the external review, the IRO shall notify the Plan, you and, if applicable, your authorized representative, of its decision to reverse the determination.

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

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

- Your pertinent medical records;
- Your health care provider's recommendation;
- Consulting reports from appropriate health care providers and other documents submitted to the Plan or its designated utilization review organization, you, your authorized representative or your treating provider;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence–based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan or its designated utilization review organization; and
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

Within one business day after the receipt of notice of assignment to conduct an external review with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the IRO will select one or more clinical reviewers, as it determines is appropriate, to conduct the external review, which clinical reviewers must meet the

minimum qualifications set forth in the Illinois Health Carrier External Review Act, and neither you, your authorized representative, if applicable, nor the Plan will choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review. Each clinical reviewer will provide a written opinion to the IRO within 20 days after being selected by the IRO to conduct the external review on whether the recommended or requested health care service or treatment should be covered.

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

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

The written notice will include:

1. A general description of the reason for the request for external review;
2. The date the IRO received the assignment from the Director;
3. The time period during which the external review was conducted;
4. References to the evidence or documentation including the evidence-based standards, considered in reaching its decision or, in the case of external reviews of experimental or investigational services or treatments, the written opinion of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
5. The date of its decisions;
6. The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and
7. The rationale for its decision.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination. 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, your author-

ized representative, if applicable, and the Plan will receive written notice from the IRO.

Standard External Review

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

2. Expedited External Review

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

you received emergency services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of a Final Adverse Determination of if the Plan fails to provide a decision on a request for an expedited internal appeal within 48 hours.

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

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

Your request for an expedited independent external review may be submitted to the Director either orally (by calling 877-850-4740) or in writing as set forth above for requests for standard external review.

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

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

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

As expeditiously as your medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited external review), the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the Director, the Plan, you and, if applicable, your authorized representative. If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the Director, the Plan and, if applicable, your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of experimental or investigational treatments, each clinical reviewer shall provide an opinion orally or in writing to the assigned IRO as expeditiously as your medical condition or circumstances requires, but in no event less than five calendar days after being selected. Within 48 hours after the date it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing to the Director, the Plan, you and your authorized representative, if applicable.

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

The assigned IRO is not bound by any decisions or conclusions reached during the Plan's utilization review process or the Plan's internal appeal process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program if the IRO determines that the health care services being appealed were medically appropriate.

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

Expedited External Review

Expedited External Review	Timing
You may file a request for an expedited external review after the date of receipt of a notice prior to Final Adverse Determination:	**immediately**
You may file a request for an expedited external review if the Plan fails to provide a decision on a request for an expedited internal appeal within:	**48 hours**

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

External Review of Experimental or Investigational Treatment

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

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

OTHER THINGS YOU SHOULD KNOW

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits have been provided for Covered Services described in this Policy, you agree:

a. the Plan has the right to reimbursement for all benefits the Plan provided from any and all damages collected from the third party for those same expenses, whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury:

   (i) in the case of health care facilities and certain contracted Providers, the calculation of any lien shall be based on the amount the Plan charges the group's experience for Covered Services rendered to you; and

   (ii) in the case of Providers other than health care facilities, the calculation of any lien shall be based on the Plan's benefit payment for Covered Services rendered to you.

b. the Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Plan provided for that sickness or injury. The Plan shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses the Plan has provided as a result of that sickness or injury.

For the purposes of this provision, the cost of benefits provided will be the charges that would have been billed if you had not been enrolled under this benefit program.

You are required to furnish any information or assistance and to provide any documents that the Plan may request in order to obtain its rights under this provision.

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

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

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

— receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which the Plan was obligated to pay the Provider or supplier, or

— pay Providers or suppliers substantially less than their Claim Charges for goods or services, by discount or otherwise, or

— receive from Providers or suppliers other substantial allowances under the Plan's contracts with them.

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

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

INTER-PLAN ARRANGEMENTS

Out-of-Area Services

The Plan has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you obtain health care services outside of your Plan's service area and your Participating IPA's/Participating Medical Group's service area (collectively referred to in this section as "the service area"), the Claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside the service area, you will receive it from one of two kinds of health care Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("non-participating Providers") do not contract with the Host Blue. The Plan's payment practices in both instances are described below.

The Plan covers only limited health care services received outside of the service area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care, urgent care and follow-up care obtained outside the geographic area of the service area. Any other services will not be covered when processing through any Inter-Plan Arrangements, unless authorized by your Primary Care Physician ("PCP") or Women's Principal Health Care Provider ("WPHCP").

BlueCard® Program

Under the BlueCard Program, when you obtain Out-of-Area Covered Healthcare Services, as defined above, from a health care Provider participating with a Host Blue, the Plan will remain responsible for what we agreed to in the contract. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating health care Provider will automatically file a Claim for the Out-of-Area Covered Healthcare Services provided to you, so

there are no claim forms for you to fill out. You will be responsible for the Copayment and/or Coinsurance amount, as stated in this Certificate.

Emergency Care Services:

If you experience a medical emergency while traveling outside the service area, go to the nearest emergency facility, urgent care facility, or other health care Provider.

Whenever you receive Out-of-Area Covered Healthcare Services outside the service area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

— The billed charges for your Covered Services, or

— The negotiated price that the Host Blue makes available to the Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, also take into account adjustments to correct for over or underestimation of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Plan use[s] for your claim because they will not be applied after a Claim has already been paid.

Non-Participating Healthcare Providers Outside The Service Area

Liability Calculation

a. In General:

   Except for emergency care and urgent care, services received from a non-participating Provider outside of the service area will not be covered.

   For emergency care and urgent care services received from non-participating Providers outside of your Participating IPA's/Participating Medical Group's service area, but within the Plan's service area, please refer to the EMERGENCY CARE BENEFITS section of this Certificate.

   For emergency care and urgent care services that are provided outside of the service area by a non-participating Provider, the amount(s) you pay for such services will be calculated using the methodology described in the EMERGENCY CARE BENEFITS section for non-participating Providers located inside the service area. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

b. Exceptions:

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

BlueCard Worldwide® Program

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you may be able to take advantage of the BlueCard Worldwide Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the 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 United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the 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, will arrange a Physician appointment or hospitalization, if necessary.

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.

Outpatient Services

Physicians, urgent care centers and other outpatient Providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

Submitting a BlueCard Worldwide® Claim

When you pay for Covered Services outside the BlueCard service area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a BlueCard Worldwide International Claim form and send the Claim form 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.

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Plan's Separate Financial Arrangements with Prescription Drug Providers

The Plan hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Plan is a party, including all persons covered under this Certificate. Under its contracts with Participating Prescription Drug Providers, the Plan may receive from these Providers discounts for prescription drugs dispensed to you. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

For the 90-day supply prescription drug program 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 90-day supply prescription drug program and/or Specialty Pharmacy program. The Plan pays a fee to Prime for Pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and home delivery processing.

"Weighted Paid Claim" refers to the methodology of counting Claims for purposes of determining the Plan's fee payment to Prime. Each retail (including Claims dispensed through PBM's Specialty Pharmacy program) paid Claim equals one Weighted Paid Claim; each extended supply or home delivered order paid Claim equals three Weighted Paid Claims. However, the Plan pays Prime a Program Management Fee ("PMF") on a per paid claim basis. "Funding Levers" means a mechanism through with the Plan 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 the Plan, may include rebates and retail spread. The Plan's net fee owed to Prime for core services will be offset by the Funding Levers. The Plan pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixes dollar about per Weighted Paid Claim.

The amounts received by Prime from the Plan, Pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a Claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Plan (as described above), administrative fees charged by Prime to Pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Certificate. Addition-

al 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 the Plan and other Blue Plan operating divisions.

Plan's Separate Financial Arrangements with Pharmacy Benefit Managers

The Plan owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Plan has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Plan's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Plan. Neither the Group nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

All benefit payments may be made by the Plan directly to any Provider furnishing the Covered Services for which such payment is due, and the Plan is authorized by you to make such payments directly to such Providers. However, the Plan reserves the right to pay any benefits that are payable under the terms of this Certificate directly to you, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by the Plan sufficiently in advance of the Plan's benefit payment. The Plan reserves the right to require submission of a copy of the Assignment of Benefit Payment.

You will not receive any notices regarding Covered Services received from your Primary Care Physician (or other Providers who are part of your Participating IPA/Participating Medical Group) because Claims do not have to be filed for those services.

Once Covered Services are rendered by a Provider, you have no right to request that the Plan not pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Plan will have no liability to you or any other person because of its rejection of such request.

Except for the assignment of benefit payment described above, neither this Certificate nor a covered person's Claim for payment of benefits under this Certificate is assignable in whole or in part to any person or entity at any time, and coverage under this Certificate is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage.

COVERED SERVICES EXPENSE LIMITATION

If, during any calendar year, you have paid Copayments, deductibles and/or any Coinsurance amount for Covered Services under this Certificate the total amount of which equals $3,000 per enrollee or $6,000 per family, your benefits for any additional Covered Services that you may receive during that calendar year, in-

cluding any Copayment, deductible and/or Coinsurance amounts, will be reimbursed by the Plan. Should the federal government adjust the deductible and/or out-of-pocket limit amount(s) for high deductible health plans, the deductible and/or the out-of-pocket expense limit amount(s) in this Certificate will be adjusted accordingly.

In the event your Physician or the Hospital requires you to pay any additional Copayments, deductible and/or Coinsurance amounts after you have met the above provision, upon receipt of properly authenticated documentation, the Plan will reimburse to you, the amount of those Copayments, deductibles and/or Coinsurance amounts.

Copayments and deductibles required under this Certificate are not to exceed 50% of the usual and customary fee for any single service.

The above Covered Services expense provisions are not applicable to the benefits described in the following sections of this Certificate: Supplemental Benefits; Outpatient Prescription Drug Program Benefits.

YOUR PROVIDER RELATIONSHIPS

The choice of a Hospital, Participating IPA, Participating Medical Group, Primary Care Physician or any other Provider is solely your choice and the Plan will not interfere with your relationship with any Provider.

The Plan does not itself undertake to provide health care services, but solely to arrange for the provision of health care services and to make payments to Providers for the Covered Services received by you. The Plan is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Plan. Any contractual relationship between a Physician and a Hospital or other Provider should not be construed to mean that the Plan is providing professional service.

Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to any Group (other than as an individual Covered Person) or any Group's ERISA Health Benefit Program.

FAILURE OF YOUR PARTICIPATING IPA OR PARTICIPATING MEDICAL GROUP TO PERFORM UNDER ITS CONTRACT

Should your Participating IPA or Participating Medical Group fail to perform under the terms of its contract with the Plan, or fail to renew such contract, the benefits of this Certificate will be provided for you for Covered Services received from other Providers limited to Covered Services received during a thirty day period beginning on the date of the Participating IPA's/Participating Medical Group's failure to perform or failure to renew its contract with the Plan. During this thirty day period, you will have the choice of transferring your enrollment to another Participating IPA or Participating Medical Group or of transferring your coverage to any other health care coverage then being offered by your Group to its members. Your transferred enrollment or coverage will be effective thirty-one

days from the date your Participating IPA or Participating Medical Group failed to perform or failed to renew its contract with the Plan.

ENTIRE POLICY

The Group Policy, including the Certificate, any Addenda and/or Riders, the Benefit Program Application of the Group for the Policy and the individual applications, if any, of the Enrollees constitutes the entire contract of coverage between the Group and the Plan.

AGENCY RELATIONSHIPS

Your Group is your agent under this Certificate. Your Group is not the agent of the Plan.

NOTICES

Any information or notice which you furnish to the Plan under this Certificate must be in writing and sent to the Plan at its offices at 300 East Randolph Street, Chicago, Illinois, 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which the Plan furnishes to you must be in writing and sent to you at your address as it appears on the Plan's records or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Plan's records.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate until at least 60 days have elapsed since a Claim has been furnished to the Plan in accordance with the requirements of this Certificate. In addition, no such action may be brought once 3 years have elapsed from the date that a Claim is required to be furnished to the Plan in accordance with the requirements of this Certificate.

VALUE BASED DESIGN PROGRAMS

The Plan has the right to offer a health behavior wellness, maintenance, or improvement programs that allows 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 the Plan or an entity chosen by the Plan to administer such programs. In addition, discount programs for various health and wellness-related or insurance-related items and services may be available from time to time. Such programs may be discontinued without notice. Individuals unable to participate in these incentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, the Plan will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards. Contact the Plan for additional information regarding any value based programs offered by the Plan. Contact your employer for additional information regarding any value based programs offered by your employer.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan shall, at its own expense, have the right and opportunity to examine the person of a covered person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Certificate, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnification on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Plan or its agent, and agrees that any such Provider, person, or other entity may furnish to the Plan or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Plan may furnish similar information and records (or copies of records) to Providers, other Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Plan and/or your employer or group administrator information regarding you or your dependents becoming eligible for Medicare, termination of Medicare eligibility, or any change in Medicare eligibility status, in order that the Plan be able to make Claim Payments in accordance with MSP laws.

MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, by the Host Blues whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by your Group, but solely as a result of a reduction in force, plant/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Blue Cross and Blue Shield of Illinois offers to, you, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, Blue Cross and Blue Shield of Illinois may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Policy the Group has with Blue Cross and Blue Shield of Illinois to the extent reasonably necessary to enable the

relevant Host Blues to offer you coverage continuity through replacement coverage.

DEFINITIONS

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. The definitions of these words are listed below in alphabetical order. **These defined words will always be capitalized when used in this Certificate.**

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.

Approved Clinical Trial .....means a phase I, phase II, or phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

a) A federally funded or approved trial,

b) A clinical trial conducted under an FDA investigational new drug application, or

c) A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Autism Spectrum Disorder(s) .....means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including Asperger's disorder and pervasive developmental disorders not otherwise specified.

Behavioral Health Practitioner .....means a Physician or professional Provider who is duly licensed to render services for the treatment of Mental Illness, Serious Mental Illness or Chemical Dependency Treatment.

Certificate .....means this booklet and your application for coverage under the Plan 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:

(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 Registered Nurse Anesthetist (CRNA) .....means a person who (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

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

Chiropractor .....means a duly licensed chiropractor.

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

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

Claim Charge .....means the amount which appears on a Claim as the Provider's or supplier's charge for goods or services furnished to you, without adjustment or reduction and regardless of any separate financial arrangement between the Plan and a particular Provider or supplier. (See provisions of this Certificate regarding "Plan's Separate Financial Arrangements with Providers.")

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

Clinical Appeal .....means an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that do not meet the definition of an Urgent/Expedited Clinical Appeal.

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

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

Coordinated Home Care Program .....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.)

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

Continuous Ambulatory Peritoneal Dialysis Treatment .....means a continuous dialysis process using a patient's peritoneal membrane as a dialyzer.

Copayment .....means a specified dollar amount that you are required to pay towards a Covered Service.

Coverage Date .....means the date on which your coverage under this Certificate begins.

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

Creditable Coverage .....means coverage you had under any of the following:

a) A group health plan.

b) 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.

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

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

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

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

g) A State health benefits risk pool.

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

i) 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.

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

k) 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 or professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications etc.) and are to assist with activities of daily living, (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

Dentist .....means a duly licensed dentist.

Diagnostic Service .....means tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests 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.

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

Electroconvulsive Therapy .....means a medical procedure in which a brief application of an electric stimulus is used to produce a generalized seizure.

Eligible Person .....means an employee of the Group who meets the eligibility requirements for this health coverage, as described in the ELIGIBILITY SECTION of this Certificate.

Emergency Condition .....means an accidental bodily injury or a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

b) serious impairment to bodily functions; or

c) 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 Services .....means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the Hospital,

such further medical examination and treatment as are required to stabilize the patient.

Enrollee .....means the person who has applied for coverage under this Certificate and to whom the Plan has issued an identification card.

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

Family Coverage .....means that your application for coverage was for yourself and other eligible members of your family.

Formulary Drug .....means a brand name prescription drug that has been designated as a preferred drug by the Plan. The listing of drugs designated as being Formulary Drugs may be amended from time to time by the Plan.

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.

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

Hospice Care Program Provider .....means an organization duly licensed to provide Hospice Care Program service.

Hospital .....means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled. It does not include health resorts, rest homes, nursing homes, custodial homes for the aged or similar institutions.

Individual Coverage .....means that your application for coverage was only for yourself.

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

Investigational .....means procedures, drugs, devices, services and/or supplies which (a) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (b) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to a covered person, and (c) specifically with respect to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to the covered person.

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

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

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy .....means therapy administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Marriage and Family Therapist .....means a duly licensed marriage and family therapist.

Medical Care .....means the ordinary and usual professional services rendered by a Physician, Behavioral Health Practitioner, or other specified Provider during a professional visit, for the treatment of an illness or injury.

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

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

Mental Illness .....means those illnesses classified as mental disorders in the edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association which is current as of the date services are rendered to a patient.

"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; and

(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-Clinical Appeal .....means an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

Occupational Therapy .....means a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

Ongoing Course of Treatment .....means the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a Physician because of the potential for changes in the therapeutic regimen.

Optometrist .....means a duly licensed optometrist.

Outpatient .....means that you are receiving treatment while not an Inpatient.

Partial Hospitalization Treatment Program .....means a Hospital's planned therapeutic treatment program, which has been approved by your Participating IPA or Participating Medical Group, in which patients with Mental Illness spend days or nights.

Participating IPA .....means any duly organized Individual Practice Association of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

Participating Medical Group .....means any duly organized group of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

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

Physical Therapy .....means the treatment by physical means by or under the supervision of a qualified physical therapist.

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

Physician Assistant .....means a duly licensed physician assistant performing under the direct supervision of a Physician.

Plan .....Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association of which BlueAdvantage HMO is a product line.

Podiatrist .....means a duly licensed podiatrist.

Policy .....means the agreement between the Plan and the Group, including the Certificate, any addenda or riders that apply, the Benefit Program Application of the Group and the individual applications, if any, of the persons covered under the Policy.

Prescription Drug Provider .....means any Pharmacy which regularly dispenses drugs.

a) **Participating Prescription Drug Provider** .....means a Prescription Drug Provider which has entered into a written agreement with this Plan, or any entity designated by the Plan to administer its prescription drug program, to provide services to you at the time services are rendered to you and, for Pharmacies located in the state of Illinois, which has direct on-line computer access to the Plan or such administrative entity.

b) **Non-Participating Prescription Drug Provider** .....means a Prescription Drug Provider which does not meet the definition of a Participating Prescription Drug Provider.

Primary Care Physician (PCP) .....means a Provider who is a member or employee of or who is affiliated with or engaged by a Participating IPA or Participating Medical Group and who is a) a Physician who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics, psychiatry or family practice, or b) a Chiropractor,

and who you have selected to be primarily responsible for assessing, treating or coordinating your health care needs.

Private Duty Nursing Service .....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing Service does not include Custodial Care Service.

Provider .....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) duly licensed to render Covered Services to you.

Provider's Charge .....means a) in the case of your Primary Care Physician or another Physician who is affiliated with your Participating IPA/Participating Medical Group, the amount that such Physician would have charged for a good or service had you not been enrolled under this benefit program or b) in the case of a Provider or supplier which is not affiliated with your Participating IPA/Participating Medical Group, such Provider's or supplier's Claim Charge for Covered Services, unless otherwise agreed to by the Plan and the Provider or supplier.

Psychologist .....means:

a) a Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologist Registration Act" (111 Ill. Rev. Stat. §5301 et seq., as amended or substituted); or

b) in a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice; or

c) if practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Substance Use Disorder and who meets the following qualifications:

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

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

Radiation Therapy .....means the use of ionizing radiation in the treatment of a medical illness or condition.

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, boarding houses or other facilities that provide primarily a supportive environment and that address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders.

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

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.

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

Specialist Physician .....means a Provider with a contractual relationship or affiliation with the Participating IPA/Participating Medical Group who does not meet the definition of a Primary Care Physician, Woman's Principal Health Care Provider, or Behavioral Health Practitioner.

Speech Therapy .....means treatment for the correction of a speech impairment, including pervasive developmental disorders.

Standing Referral .....means a written referral from your Primary Care Physician or Woman's Principal Health Care Provider for an Ongoing Course of Treatment pursuant to a treatment plan specifying needed services and time frames as determined by your Primary Care Physician or Woman's Principal Health Care Provider, the consulting Physician or Provider and the Plan.

Substance Use Disorder .....means 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 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 which is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

Surgery .....means the performance of any medically recognized, non-Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Plan.

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 the Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

Urgent/Expedited Clinical Appeal .....means an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your health.

Woman's Principal Health Care Provider (WPHCP) .....means a physician licensed to practice medicine in all of its branches, specializing in obstetrics or gynecology or specializing in family practice.

CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

NOTE: The CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Public employees and surviving spouses or surviving parties to a Civil Union of such employees who are eligible for continued group health coverage under Sections 367 (g), (h) and (i) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The public employee, surviving spouse or surviving party to a Civil Union must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such employee, spouse or party to a Civil Union has Family Coverage, he/she may continue to have Family Coverage.
2. Group coverage can be continued until the public employee, surviving spouse or surviving party to a Civil Union is no longer eligible, as specified in Sections 367 (g), (h) and (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse or surviving party to a Civil Union will end if such spouse or surviving party to a Civil Union should remarry or enter another Civil Union. It is the employee/spouse's or surviving party to a Civil Union's responsibility to inform the Plan of his/her loss of eligibility.
3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the public employee, surviving spouse or surviving party to a Civil Union.
4. If the public employee, surviving spouse or surviving party to a Civil Union should choose to convert his or her group coverage to a "direct-payment" conversion policy, as described above under Conversion Privilege, such employee, spouse or party to a Civil Union will no longer be eligible for this continuation of group coverage.

CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED FIREMEN

NOTE: The CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED FIREMEN applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Firemen and surviving spouses or surviving parties to a Civil Union of such firemen who are eligible for continued group health coverage under Section 367 (f) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The fireman, surviving spouse or surviving party to a Civil Union must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such fireman, spouse or party to a Civil Union has Family Coverage, he/she may continue to have Family Coverage.
2. Group coverage can be continued until the fireman, surviving spouse or surviving party to a Civil Union is no longer eligible, as specified in Section 367 (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse or surviving party to a Civil Union will end if such spouse or party to a Civil Union should remarry or enter another Civil Union. It is the employee/spouse's or surviving party to a Civil Union's responsibility to inform the Plan of his/her loss of eligibility.
3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the fireman, surviving spouse or surviving party to a Civil Union.
4. If the fireman, surviving spouse or surviving party to a Civil Union should choose to convert his or her group coverage to a "direct-payment" conversion policy, as described above under Conversion Privilege, such fireman, spouse or party to a Civil Union will no longer be eligible for this continuation of group coverage.

CONTINUATION OF COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES

NOTE: The CONTINUATION OF COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

If you are a full-time law enforcement, correctional or correctional probation officer, or firefighter and are eligible for continued group health insurance under the Public Safety Employee Benefits Act (820 ILCS 320), you may maintain such group health insurance under the following conditions:

1. You and your eligible dependents must have been insured under this Certificate on the day immediately preceding the date of eligibility for continued group health insurance.
2. Your Group shall pay the entire premium of the group health insurance coverage for you, your spouse, your party to a Civil Union and each dependent child until the child reaches the limiting age under this Certificate or until the end of the calendar year in which the child reaches the limiting age under this Certificate, whichever is later.
3. If you subsequently die, your Group shall continue to pay the entire health insurance premium for your surviving spouse or your surviving party to a Civil Union until he or she remarries or enters another Civil Union and for your dependent children under the conditions established in 2. above.
4. Health insurance benefits under this Certificate shall be reduced by health insurance benefits payable from any other source.

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