BlueCross BlueShield of Illinois

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

Your Health Care Benefits Program

300 East Randolph Street | Chicago, IL 60601-5099

Or call us at the phone number on the back of your identification card.

The Thresholds

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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

CUSTOMER ASSISTANCE

Customer Service – The 24/7 Nurseline can help when you have a **health-related question**. The 24/7 Nurseline is staffed by personnel who are available 24 hours a day, 7 days a week (24/7), and can provide general health information on certain topics.

24/7 Nurseline toll-free telephone number: 1-800-299-0274 When you have a benefit question or concern, you may call Blue Cross and Blue Shield, A Division of Health Care Service Corporation, A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross Blue Shield Association (herein called Blue Cross and Blue Shield, "BCBSIL"), Monday through Friday from 8 a.m. - 6 p.m., Central Standard Time (CST/CDT), at the toll-free telephone number shown on the back of your Identification Card.

Send all **written inquiries/Prior Authorization requests** and submit **medical/surgical Claims*** to:

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

Prior Authorizations: Medical/Surgical Services – For Prior Authorization requests, call a health services representative, Monday through Friday 8 a.m. - 6 p.m., CST/CDT. Written requests should be sent to the address given above. You may call Blue Cross and Blue Shield toll-free at:

Toll-free telephone number: 1-800-635-1928

Prior Authorizations: Behavioral Health Services – For inquiries or Prior Authorizations related to behavioral health services, you may call the Blue Cross and Blue Shield Behavioral Health Unit:

24/7 toll-free telephone number: 1-800-851-7498

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

Website – Visit the Blue Cross and Blue Shield of Illinois website at:

www.bcbsil.com

***Exceptions to Claim Submission Procedures** – Claims for health care services received from Providers that do not contract **directly** with Blue Cross and Blue Shield, should be sent to the Blue Cross and Blue Shield Plan in the state where services were received. See *Claim Filing and Appeals Procedures* for details on submitting Claims.

A message from

BLUE CROSS AND BLUE SHIELD OF ILLINOIS

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

In this Certificate, we refer to our company as “Blue Cross and Blue Shield” and we refer to the employer, group, trust or other entity that has contracted with Blue Cross and Blue Shield of Illinois for this program as the “Group.” The *Definitions* section will explain the meaning of many of the terms used in this Certificate. If you have Family Coverage, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

Please take time getting to know your benefit program, including its benefit limits and exclusions, by reviewing this Certificate and any enclosures. Learning how this plan works will make the best use of your health care benefits.

If you have any questions once you have read this Certificate, talk to your Group Administrator or call us at the number listed on the back of your Identification Card, or as listed in *Customer Assistance* on the inside front cover. It is important to us that you understand the protection this coverage gives you.

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

Sincerely,

Brian Snell
President

BCS-CB-LG-2025-IL 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

NOTICE

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

Please refer to the provision entitled "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers" and "Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers" under the *General Provisions* section of this Certificate for a further explanation of these arrangements.

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

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

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SUMMARY OF BENEFITS

The following information summarizes the major medical benefits available under your benefit plan. To get the most out of your coverage, it is important that you carefully read the sections following the *Summary of Benefits* for more details explaining your benefits.

YOUR PROGRAM DEDUCTIBLE APPLIES TO ALL BENEFITS DESCRIBED BELOW, UNLESS OTHERWISE SPECIFIED IN THIS CERTIFICATE. ALL COINSURANCE AMOUNTS DESCRIBED BELOW THAT YOU PAY ARE A PERCENTAGE OF THE ELIGIBLE CHARGE OR THE MAXIMUM ALLOWANCE.

Deductible	**In-Network Provider**	**Out-of-Network and Non-Plan Provider**
Individual Deductible	$1,000 per benefit period	$3,000 per benefit period
Family Deductible	$3,000 per benefit period	$9,000 per benefit period
Inpatient Hospital Deductible	None	$300 per admission
Outpatient Hospital Deductible	None	None
Out-of-Pocket Expense	**In-Network Provider**	**Out-of-Network Provider***
Individual Out-of-Pocket Expense Limit	$4,500 per benefit period	$13,000 per benefit period
Family Out-of-Pocket Expense Limit	$9,000 per benefit period	$39,000 per benefit period
Inpatient Hospital Services	**In-Network Provider**	**Out-of-Network Provider****
Inpatient Hospital Payment Level	20% of the Eligible Charge	50% of the Eligible Charge
Outpatient Hospital Services	**In-Network Provider**	**Out-of-Network Provider****
Outpatient Hospital Payment Level	20% of the Eligible Charge	50% of the Eligible Charge
Outpatient Surgical Services	20% of the Eligible Charge, no Deductible	50% of the Eligible Charge, no Deductible
Outpatient Diagnostic Services	20% of the Eligible Charge, no Deductible	50% of the Eligible Charge, no Deductible
Outpatient Diagnostic Services (Labs, x-rays and other Diagnostic Services from an Independent Facility)	20% of the Eligible Charge, no Deductible	50% of the Eligible Charge, no Deductible
Major Outpatient Diagnostic Services MRI, CT scans and PET scans	20% of the Eligible Charge	50% of the Eligible Charge
Facility Services†	**Plan Provider**	**Non-Plan Provider****
Skilled Nursing Facility Care	20% of the Eligible Charge	50% of the Eligible Charge
Ambulatory Surgical Facility	20% of the Eligible Charge, no Deductible	50% of the Eligible Charge
Physician Office Visits	**In-Network Provider**	**Out-of-Network Provider****
Covered Services received in a Physician's office (other than a specialist)	$30 per visit, then No Charge, no Deductible	50% of the Maximum Allowance

Covered Services received in a specialist's office	$30 per visit, then No Charge, no Deductible	50% of the Maximum Allowance
Physician and Other Professional Services	**In-Network Provider**	**Out-of-Network Provider****
Professional Payment Level	20% of the Maximum Allowance	50% of the Maximum Allowance
Outpatient Surgical Services	20% of the Maximum Allowance	50% of the Maximum Allowance
Outpatient Diagnostic Services	20% of the Maximum Allowance	50% of the Maximum Allowance
Outpatient Diagnostic Services (Labs, x-rays and other Diagnostic Services from an Independent Facility)	20% of the Maximum Allowance	50% of the Maximum Allowance
Major Outpatient Diagnostic Services MRI, CT scans and PET scans	$30 per visit, then No Charge, no Deductible	50% of the Maximum Allowance
Chiropractic and Osteopathic Services	20% of the Maximum Allowance	50% of the Maximum Allowance
Telehealth and Telemedicine Services visits	$30 per visit, then No Charge, no Deductible	50% of the Maximum Allowance
Telehealth and Telemedicine Services visits for treatment of Mental Illness	$30 per visit, then No Charge, no Deductible	50% of the Maximum Allowance
Telehealth and Telemedicine Services Specialist Physician visits	$30 per visit, then No Charge, no Deductible	50% of the Maximum Allowance
Outpatient Physical Therapy	20% of the Maximum Allowance	50% of the Maximum Allowance
Outpatient Occupational Therapy	20% of the Maximum Allowance	50% of the Maximum Allowance
Outpatient Speech Therapy	20% of the Maximum Allowance	50% of the Maximum Allowance
Additional Surgical Opinion	No Charge, no Deductible	
Virtual Visits		
Medical	$30 per visit, then No Charge, no Deductible	
Behavioral Health	$30 per visit, then No Charge, no Deductible	
Urgent Care Facility	**In-Network Provider**	**Out-of-Network Provider****
Covered Services received in an urgent care facility	20% of the Eligible Charge	50% of the Eligible Charge
Emergency Accident Care	**In-Network, Out-of-Network or Non-Plan Provider**	
Emergency Accident Care received from a Hospital (including Mental Illness or Substance Use Disorder services provided in a Hospital emergency department)	20% of the Eligible Charge	
Emergency Accident Care received from a Physician or other specified Professional Provider	20% of the Maximum Allowance	

Emergency Room Copayment	$300 per visit
Emergency Office Visit Copayment	$30 per visit, then No Charge, no Deductible
Emergency Medical Care	**In-Network, Out-of-Network or Non-Plan Provider**
Emergency Medical Care received from a Hospital (including Mental Illness or Substance Use Disorder services provided in a Hospital emergency department)	20% of the Eligible Charge
Emergency Medical Care received from a Physician or other specified Professional Provider	20% of the Maximum Allowance
Emergency Room Copayment	$300 per visit
Emergency Office Visit Copayment	$30 per visit, then No Charge, no Deductible
Other Covered Services	
Payment Level for Other Covered Services (specified in the "Other Covered Services" section under Certificate)	20% of the Eligible Charge or 20% of the Maximum Allowance
Hearing Aids	20% of the Provider's charge
Ambulance Transportation Services	20% of the Ambulance Transportation Eligible Charge
Benefit Maximums/Exclusions	
Skilled Nursing Facility Care	No limit
Coordinated Home Care Program	No limit
Chiropractic and Osteopathic Manipulations	25 visits per benefit period, as specified in the "Your Benefit Period" provision under *How Your Benefit Plan Works* section of this Certificate.
*Outpatient Physical Therapy****	110 visits per benefit period, as specified in the "Your Benefit Period" provision under How Your Benefit Plan Works section of this Certificate.
*Outpatient Occupational Therapy****	70 visits per benefit period, as specified in the "Your Benefit Period" provision under How Your Benefit Plan Works section of this Certificate.
*Outpatient Speech Therapy****	50 visits per benefit period, as specified in the "Your Benefit Period" provision under How Your Benefit Plan Works section of this Certificate.
Private Duty Nursing Service	No limit
Naprapathy Services	15 visits per benefit period, as specified in the "Your Benefit Period" provision under How Your Benefit Plan Works section of this Certificate.
Hearing Aids	No limit

For transportation and lodging benefit maximums and exclusions, please see the "Transportation and Lodging" provision under the *Special Payment and Conditions* section of this Certificate.

***There is no limit on the out-of-pocket expense limit for Covered Services received from Non-Plan Providers.**

****You will be responsible for paying the difference between the Eligible Charge and the Billed Charges, when receiving Covered Services from an Out-of-Network Provider. You will pay 50% of the Eligible Charge plus the difference between the Eligible Charge and the Billed Charges when receiving Inpatient or Outpatient Hospital Covered Services from a Non-Plan Provider. The Average Discount Percentage (as defined in the *Definitions* section of this Certificate) does not apply to Non-Plan Providers.**

*****Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any Physical Therapy, Occupational Therapy or Speech Therapy visit maximums.**

†For purposes of this benefit plan, Skilled Nursing Facility Care and Ambulatory Surgical Facilities are considered Plan and Non-Plan Providers.

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

The amount you may pay for a twin-pack of Medically Necessary epinephrine injectors, regardless of type, shall not exceed $60, when obtained from a Participating Pharmacy.

TO IDENTIFY NON-PLAN AND PLAN HOSPITALS OR FACILITIES, YOU MAY CONTACT BLUE CROSS AND BLUE SHIELD, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY, AN INDEPENDENT LICENSEE OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION (HEREIN CALLED "BLUE CROSS AND BLUE SHIELD OF ILLINOIS, "BCBSIL"), CUSTOMER SERVICE AT THE TOLL-FREE TELEPHONE NUMBER SHOWN ON THE BACK OF YOUR IDENTIFICATION CARD.

OUTPATIENT PRESCRIPTION DRUG PROGRAM – SUMMARY OF BENEFITS

The following information summarizes the benefits available under the *Outpatient Prescription Drug Program*. Carefully read the provisions specified in the *Outpatient Prescription Drug Program* section of this Certificate for additional details explaining your prescription drug benefits.

Deductible for Covered Drugs	Individual: None Family: None
Out-of-Pocket Expense Limit for Covered Drugs	Individual: $2,000 per benefit period Family: $5,300 per benefit period

Retail Pharmacy	**Participating Pharmacy**
Tier 1*	Copayment Amount: $10 per each prescription
Tier 2*	Copayment Amount: $40 per each prescription
Tier 3*	Copayment Amount: $60 per each prescription

Home Delivery Prescription Drug Program	**Participating Pharmacy** Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed
Tier 1*	Copayment Amount: $20 per each prescription
Tier 2*	Copayment Amount: $80 per each prescription
Tier 3*	Copayment Amount: $120 per each prescription

Non-Participating Pharmacy: If Covered Drugs obtained from a Non-Participating Prescription Drug Provider	When you obtain Covered Drugs, including diabetic supplies or insulin and insulin syringes from a Non-Participating Pharmacy (other than a Participating Pharmacy), benefits will be provided at 75% of the Eligible Charge for each prescription, minus the Participating Pharmacy Copayment Amount or Coinsurance Amount. If a deductible or an out-of-pocket expense limit for Covered Drugs is shown in this *Summary of Benefits* above, then only your Copayment Amount or Coinsurance Amount will apply to the out-of-pocket expense limit. Any additional charge will not be applied to your deductible or out-of-pocket expense limit.

Specialty Pharmacy Program: If covered Specialty Drugs obtained from a non-preferred Specialty Pharmacy Provider	When you obtain Covered Specialty Drugs from a non-preferred Specialty Pharmacy Provider, benefits will be provided at 75% of the Eligible Charge for each prescription, minus the Copayment Amount or Coinsurance Amount. If a deductible or an out-of-pocket expense limit for Covered Drugs is shown in this *Summary of Benefits* above, then only your Copayment Amount or Coinsurance Amount will apply to the out-of-pocket expense limit. Any additional charge will not be applied to your deductible or out-of-pocket expense limit. Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply, if allowed by your plan benefits. Cost-share will be based on the day supply dispensed. (1-30 day supply; 31-60 day supply; 61-90 day supply).

Additional Provisions	The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $35, when obtained from a Participating Pharmacy. **The amount you may pay for a twin-pack of Medically Necessary epinephrine injectors, regardless of type, shall not exceed $60, when obtained from a Participating Pharmacy.**

Note: The applicable cost-sharing (by tier) and the cost difference between the generic and brand will never exceed the overall actual price of the drug.

***For information on the type of drugs covered under each respective tier level, please see the "Benefit Payment for Prescription Drugs" provision under the *Outpatient Prescription Drug Program* section of this Certificate.**

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

HOW YOUR BENEFIT PLAN WORKS

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

THE PROVIDER DIRECTORY

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

YOUR BENEFIT CHOICES

When you need health care, you have the choice of obtaining benefits from either an In-Network Provider, Out-of-Network Provider or a Non-Plan Provider. It is important to understand the differences between them. Before you receive treatment, schedule Surgery or schedule a Hospital admission, ask each of your Providers if he/she is a Blue Cross and Blue Shield In-Network Provider. (A Physician's or other Provider's contract may be separate from the treatment facility's contract.) Your choice can make a difference in the amount you pay and the benefits available to you.

Should you wish to know the Maximum Allowance for a specific procedure, or whether a particular Provider is an In-Network Provider, please contact your Professional Provider or Blue Cross and Blue Shield.

In-Network Providers

In-Network Providers have agreed not to bill you for Covered Services for an amount exceeding the Eligible Charge or Maximum Allowance. When you receive Covered Services from an In-Network, you will only be responsible for the difference between the Blue Cross and Blue Shield benefit payment and the Eligible Charge or Maximum Allowance for the specific Covered Service. This means your program Deductible, Copayment and Coinsurance amounts.

Out-of-Network Providers

When you receive Covered Services from an Out-of-Network Provider, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Non-Plan Providers

When you receive Covered Services from a Non-Plan Provider, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and the Non-Plan Provider's charge to you. In addition, there is no limit on the out-of-pocket expense limit for Covered Services received from Non-Plan Providers.

Medically Necessary Hospital Services Received from an Out-of-Network or Non-Plan Provider

If you must receive Medically Necessary Hospital Covered Services from an Out-of-Network or Non-Plan Provider and these Covered Services are not available from an In-Network Provider, Blue Cross and Blue Shield will pay for the Covered Services that you receive from an Out-of-Network Provider or Non-Plan Provider at the payment level of an In-Network Provider.

Out-of-Network Facility-Based Physicians and Providers

If you receive Covered Services from an In-Network Hospital or from a Plan Ambulatory Surgical Facility and the Covered Services are provided by any of the following Out-of-Network Providers and such services are not available from an In-Network Provider, you will not incur a greater out-of-pocket cost than you would have incurred if the Covered Services were provided by an In-Network Provider. These Out-of-Network Providers include:

1. An anesthesiologist (including a Certified Registered Nurse Anesthetist);

2. A pathologist;

3. A radiologist;

4. A neonatologist;

5. An emergency room Physician;

6. An assistant surgeon (if the primary surgeon is an In-Network Provider); and/or

7. Any other Physician who is not an In-Network Provider.

However, if you willfully choose to receive Covered Services from an Out-of-Network Provider when an In-Network Professional Provider is available or you or the Out-of-Network Provider rejects the assignment of benefits, the above provision will not apply to you.

YOUR BENEFIT PERIOD

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

YOUR COST SHARING

You may have to satisfy a Deductible amount(s), a Copayment amount(s), and/or a Coinsurance amount(s) before you receive benefits. Your benefit plan may have separate amounts that are applicable to Covered Services rendered by an In-Network Provider(s), Out-of-Network Provider(s) or Non-Plan Provider(s), and rendered by an In-Network Provider(s), Out-of-Network Provider(s) and Non-Plan Provider(s) for out-of-pocket expense limit(s).

Before reading the description of your benefits, you should understand the cost sharing features shown under the *Summary of Benefits* section of this Certificate.

YOUR DEDUCTIBLE

Individual Coverage

If you have Individual Coverage, for each benefit period, you must satisfy the Deductible amount(s), if any, shown under the *Summary of Benefits* section of this Certificate before receiving benefits. In other words, after you have Claims for Covered Services for more than the Deductible amount in a benefit period, your benefits will begin, unless otherwise described in this Certificate. This Deductible will be referred to as the program Deductible.

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

In addition to your program Deductible, each time you are admitted to a Hospital or Skilled Nursing Facility, you must satisfy the Inpatient Deductible amount(s), if any, shown under the *Summary of Benefits* section of this Certificate.

Carryover Option

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

Family Coverage with Embedded Deductible

If you have Family Coverage and a single-family member reaches the individual Deductible shown under the *Summary of Benefits* section of this Certificate, he or she will be eligible for benefits provided during that benefit period and does not have to wait for other family members to satisfy their program Deductibles. A family member may not apply more than the individual Deductible amount toward the family Deductible amount.

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

Should the federal government adjust the Deductible amount(s) applicable to this type of coverage, the Deductible amount(s) in this Certificate will be adjusted accordingly.

YOUR COPAYMENT

When you receive Covered Services (except for those services shown below) in your Physician's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to the Physician's office Copayment amount(s), if any, shown in the *Summary of Benefits*. Benefits will then be provided at the professional payment level shown in the *Summary of Benefits*. Benefits for office visits may be subject to a separate Copayment amount for Covered Services rendered in a specialist's office.

A specialist is a Provider who is <u>not</u> a:

- Behavioral Health Practitioner
- Certified Nurse-Midwife
- Certified Nurse Practitioner
- Certified Clinical Nurse Specialist
- Clinical Professional Counselor
- Clinical Social Worker
- Clinical Laboratory
- Immediate/Urgent Care Center
- Marriage and Family Therapist
- Mixed Psychiatric Group
- Mixed Specialty Group
- Neuro Psychologist
- Optician
- Optometrist
- Physician Assistant
- Retail Health Clinic

or a Physician in:

- Clinical Psychology
- Family Practice
- General Practice
- Gynecology
- Internal Medicine
- Obstetrics
- Pediatrics
- Psychiatry

The following Covered Services are not subject to an office visit Copayment. Benefits will be provided at the Professional payment level shown in the *Summary of Benefits*, unless otherwise described in this Certificate:

- Surgery
- Occupational Therapy

- Physical Therapy
- Speech Therapy
- Emergency Accident Care or Emergency Medical Care
- Chiropractic and osteopathic manipulation

YOUR COINSURANCE

For most Covered Services, you must pay a percentage of eligible expenses after you have met your program Deductible and, depending on your benefit plan. This is shown in the *Summary of Benefits* section under this Certificate. After your share has been calculated, this benefit plan pays the rest of the eligible expenses, up to maximum benefit limits, if any. You pay a lower percentage of covered charges when you visit an In-Network Provider.

OUT-OF-POCKET EXPENSE LIMIT

Individual Coverage

If you have Individual Coverage and your out-of-pocket expense during one benefit period equals the out-of-pocket expense limit(s), if any, shown under the *Summary of Benefits* section of this Certificate, then any additional eligible Claims (except for those charges specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

Family Coverage

If you have Family Coverage and your family's out-of-pocket expense during one benefit period equals the family out-of-pocket expense limit(s), if any, shown under the *Summary of Benefits* section of this Certificate, then for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded below) provided at 100% of the Eligible Charge or Maximum Allowance.

A family member may not apply more than the individual out-of-pocket expense limit toward this amount.

Exclusions

The following expenses for Covered Services rendered by an In-Network Provider(s) cannot be applied to the out-of-pocket expense limit. They will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached. They include:

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

2. The Coinsurance resulting from Covered Services rendered by an Out-of-Network Provider or a Non-Plan Provider (other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is unstable);

3. Charges for Outpatient prescription drugs;

4. Services, supplies, or charges limited or excluded under this Certificate; and

5. Expenses not covered because a benefit maximum has been reached.

The following expenses for Covered Services rendered by an Out-of-Network Provider(s) cannot be applied to the out-of-pocket expense limit. They will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached. They include:

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

2. The Coinsurance resulting from Covered Services rendered by an In-Network Provider;

3. The Coinsurance resulting from Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider facility;

4. Charges for Outpatient prescription drugs;

5. Services, supplies, or charges limited or excluded under this Certificate; and

6. Expenses not covered because a benefit maximum has been reached.

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

BENEFIT MAXIMUMS

Certain benefits may be subject to a benefit period maximum, if any, shown under the *Summary of Benefits* section of this Certificate. All benefits payable under this Certificate are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service, Blue Cross and Blue Shield will include benefit payments under both this and/or any prior or subsequent Blue Cross and Blue Shield Certificate issued to you as an Eligible Person, or a Dependent of an Eligible Person, under this Group.

UTILIZATION MANAGEMENT AND REVIEW

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on BCBSIL Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity review. If requested, services normally subject to a Post-Service Medical Necessity review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Refer to the definition of Medically Necessary under the *Definitions* section of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

PRIOR AUTHORIZATION

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

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

PRIOR AUTHORIZATION RESPONSIBILITY

In-Network Provider Prior Authorization

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

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

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

Out-of-Network Provider Prior Authorization

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

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

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

Inpatient Admissions

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

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

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

In-Network Provider Benefits will be available if you use an In-Network Plan Provider or In-Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available from In-Network Providers, Out-of-Network plan Benefits will be paid.

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

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

For Behavioral Health Inpatient Admissions please see Contacting Behavioral Health section below.

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

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

1. Maternity Care:

a. 48 hours following an uncomplicated vaginal delivery;

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

2. Treatment of Breast Cancer:

   a. 48 hours following a mastectomy;

   b. 24 hours following a lymph node dissection.

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

OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW

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

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

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

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

LENGTH OF STAY/SERVICE REVIEW

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

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

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the *Appeal Procedure* section under this Certificate.

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

RECOMMENDED CLINICAL REVIEW

Some services that do not require Prior Authorization may be subject to review for evidence of Medical Necessity for coverage determinations that may occur prior to services rendered, during the course of care or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations where you have to pay for a non-approved service. BCBSIL will review the request to determine if it meets approved BCBSIL medical policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbsil.com/find-care/where-you-go-matters/utilization-management.com for the Required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card. You or your Provider may request a Recommended Clinical Review.

Recommended Clinical Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this Certificate. Please coordinate with your Provider to submit a written request for Recommended Clinical Review.

CONTACTING BEHAVIORAL HEALTH

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

General Provisions Applicable to All Recommended Clinical Reviews

1. No Guarantee of Payment

A Recommended Clinical Review is not a guarantee of benefits or payment of benefits by the plan. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the member may have become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. Request for Additional Information

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

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or Post-Service Claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms member eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate

documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment

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

2. Request for Additional Information

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

CASE MANAGEMENT

When you receive Covered Services in an emergency room, or are hospitalized for a complex medical situation such as an organ transplant, accident or serious disease, you may be contacted by a case manager. Case managers are registered nurses (or other health care professionals) who have professional training and clinical experience. They may:

1. Answer questions about your medical condition;

2. Help you understand what to expect when you are discharged from the Hospital to your home or to another care facility; and

3. Help coordinate special care you may need.

In some cases, if your condition requires care in a Hospital, or other health care facility, the case manager may provide an alternative treatment plan. If you and your Physician choose the alternative treatment plan, then alternative benefits may be provided as described under this Certificate.

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

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

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care, Outpatient services, behavioral health services or other health care services or supplies are not Medically Necessary will be based on generally accepted medical standards. Should Blue Cross and Blue Shield determine that the Inpatient care. Outpatient services, behavioral health services or other health care services or supplies are not Medically Necessary, written notification of the decision, and your right to request an external review, will be provided to you, your Physician or Behavioral Health Practitioner and/or the Hospital, facility or other Provider within 24 hours. It will specify the dates or services that are not considered Covered Services. For Inpatient care or behavioral health services, such written notice will be sent within 15 calendar days of the date the decision was made. For further details regarding Medically Necessary care and other exclusions from coverage under this Certificate, see the sections entitled *Exclusions—What Is Not Covered* and *Definitions*.

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

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

Blue Cross and Blue Shield will make the initial decision whether hospitalization, Outpatient service or other health care services or supplies were not Medically Necessary. In most instances, this decision is made by Blue Cross and Blue Shield after you have been hospitalized, or have received other health care services or supplies, and after a Claim for payment has been submitted.

Remember that your Blue Cross and Blue Shield Certificate does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve an Inpatient stay, Outpatient service or other health care service, or supplies does not of itself make such admission, service or supplies Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views an admission or other health care services or supplies as Medically Necessary, Blue Cross and Blue Shield will not pay for the admission, services or supplies if Blue Cross and Blue Shield and the Blue Cross and Blue Shield Physician decide they were not Medically Necessary, except as otherwise provided in the *Appeal Procedure* section under this Certificate.

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

terms of benefit coverage, provider contract language, medical and medical management policies, utilization or clinical review or utilization management policies, clinical payment and coding policies as well as coding software logic, including but not limited to lab management or other coding logic or edits.

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

APPEAL PROCEDURE

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

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

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

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

Additional information about appeals procedures is set forth in the “Claim Appeal Procedures” provision of the *Claim Filing and Appeals Procedures* section under this Certificate.

FAILURE TO OBTAIN PRIOR AUTHORIZATION

If Prior Authorization is not obtained:

1. BCBSIL will review the Medical Necessity of your treatment or service prior to the final benefit determination.
2. If BCBSIL determines the treatment of service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.

MEDICARE ELIGIBLE MEMBERS

The provisions of this *Utilization Review and Management* section do not apply to you if you are Medicare eligible and have secondary coverage provided under this Certificate.

EMERGENCY SERVICES

This plan provides benefits for expenses used for Emergency Accident Care and Emergency Medical Care Services when you receive Covered Services that meet the definition of Emergency Accident Care or Emergency Medical Care and are received from an In-Network, Out-of-Network or Non-Plan Provider in a Hospital emergency department.

This plan also provides benefits received for Mental Illness and Substance Use Disorder when you receive Covered Services that meet the definition of Mental Illness or Substance Use Disorder and are received from an In-Network, Out-of-Network- or Non-Plan Provider in a Hospital emergency department.

Blue Cross and Blue Shield will pay benefits at the payment levels for Emergency Accident Care or Emergency Medical Care described in the *Summary of Benefits* section under this Certificate. Benefits received for Mental Illness or Substance Use Disorder will be provided at the same payment levels as Emergency Accident Care or Emergency Medical Care.

Copayments

Each time you receive Covered Services for Emergency Accident Care or Emergency Medical Care in an emergency room, you will be responsible for the emergency room Copayment amount specified in the *Summary of Benefits* section of this Certificate. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

When you receive Covered Services for Emergency Accident Care or Emergency Medical Care in a Provider's office, benefits for office visits are subject to the emergency office visit Copayment amount specified in the *Summary of Benefits* section of this Certificate.

Criminal Sexual Assault

This plan provides benefits for Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault and attempted sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection. These Covered Services will not be subject to any Deductible, Coinsurance and/or Copayment.

Emergency Services Received from an Out-of-Network or Non-Plan Provider

This plan provides benefits for an Inpatient Hospital admission to an Out-of-Network or Non-Plan Provider due to Emergency Accident Care or Emergency Medical Care at the same payment level that you would have received had you been in an In-Network Hospital, but only for that portion of your Inpatient Hospital stay during which your Medically Necessary condition is determined to be unstable, and therefore, not permitting your safe transfer to an In-Network Hospital or other In-Network Provider.

Emergency Services Received from an Out-of-Network or Non-Plan Hospital

This plan provides benefits for an Inpatient Hospital admission to an Out-of-Network or Non-Plan Hospital due to Emergency Accident Care or Emergency Medical Care at the Out-of-Network Hospital payment level, or the Non-Plan Hospital payment level (depending on the type of Provider), but only for that portion of your Inpatient Hospital stay during which your Medically Necessary condition is determined as being stabilized, and therefore, permitting your safe transfer to an In-Network Hospital or other In-Network Provider.

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

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

If you disagree with Blue Cross and Blue Shield's determination in processing your benefits as non-emergency care instead of Emergency Accident Care or Emergency Medical Care, you may call the customer service number on the back of your Identification Card. Please refer to the *Claim Filing and Appeals Procedures* section of this Certificate for specific information on your right to seek and obtain a full and fair review of your Claim.

Eligible Charge and Maximum Allowance Calculation

Unless there is anything under this Certificate to the contrary, the method used to determine the Eligible Charge or Maximum Allowance for Emergency Services will be equal to the greatest of the following three possible amounts:

1. The amount negotiated with In-Network Providers for emergency care benefits furnished; or

2. The amount for the Emergency Service calculated using the same method the In-Network Providers generally use to determine payments for Out-of-Network Provider services. However, the plan substitutes the In-Network cost sharing provisions for the Out-of-Network Provider cost-sharing provisions; or

3. The amount that would be paid under Medicare for the Emergency Services.

Each of these three amounts is calculated by excluding any Out-of-Network Provider Copayment or Coinsurance that is imposed.

HOSPITAL SERVICES, FACILITY SERVICES AND OUTPATIENT PROGRAMS

Expenses for Hospital care are usually the greatest health care cost. Your Hospital benefits will help ease the financial burden of these expensive services. This section describes the services and supplies covered by this health care plan when received from a Hospital, Skilled Nursing Facility, other facility or Outpatient program.

The Covered Services described below are subject to the payment levels stated under the *Summary of Benefits* section of this Certificate, and the terms and conditions under this Certificate. Furthermore, Blue Cross and Blue Shield provides the benefits described in this section only when you receive services on or after your Coverage Date, and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and must be regularly included in the Provider's charges.

Covered Services received from a Hospital as an Inpatient

This plan provides benefits for Covered Services received from a Hospital as an Inpatient: These include:

1. Bed, board and general nursing care when you are in:

a. A semi-private room;
b. A private room*; or
c. An intensive care unit.

2. Ancillary services such as:

a. Operating rooms;
b. Drugs;
c. Surgical dressings; and
d. Lab work.

3. Routine Patient Costs in connection with Approved Clinical Trials (as described below under the "Approved Clinical Trials" provision).

**If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.*

Important Prior Authorization Requirements

Please see the *Utilization Management and Review* section under this Certificate for information regarding Prior Authorization requirements.

Preadmission Testing

If you are scheduled to have Surgery on an Inpatient basis, this plan provides benefits for preoperative tests as an Outpatient, if the tests would have been covered had you received them as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

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

Covered Services received from a Hospital as an Outpatient

This plan provides benefits for Covered Services received from a Hospital as an Outpatient. These include:

1. Chemotherapy;

2. Electroconvulsive therapy;

3. Radiation therapy treatments;

4. Renal Dialysis Treatments *if received in*:

a. A Hospital;
b. A Dialysis Facility; or
c. Your home under the supervision of a Hospital or Dialysis Facility;

5. Urgent Care; and

6. Routine Patient Costs in connection with Approved Clinical Trials (as described below under the "Approved Clinical Trials" provision).

Outpatient Surgical Services

This plan provides benefits for Surgery and Diagnostic Service related to surgical services. The Diagnostic Services must be received on the same day as the Surgery. The plan also covers Outpatient Surgery performed in an Ambulatory Surgical Facility.

Outpatient Diagnostic Services

This plan provides benefits when you are an Outpatient and these services are related to Surgery or Medical Care.

Approved Clinical Trials

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

Skilled Nursing Facility Care

This plan provides benefits for Covered Services when you receive them in a Skilled Nursing Facility. These include:

1. Bed, board and general nursing care; and

2. Ancillary services (such as drugs and surgical dressings or supplies).

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

Important Prior Authorization Requirements

Please see the *Utilization Management and Review* section under this Certificate for information regarding Prior Authorization requirements.

Partial Hospitalization Treatment Program

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

Coordinated Home Care Program

This plan provides benefits for Covered Services under a Coordinated Home Care Program. These are provided at the same level as shown in the *Summary of Benefits* for Inpatient Hospital Covered Services.

Important Prior Authorization Requirements

Please see the *Utilization Management and Review* section under this Certificate for information regarding Prior Authorization requirements.

Hospice Care Program

This plan provides benefits for Hospice Care Program Services if these services are provided by a Hospice Care Program Provider. However, for benefits to be available:

1. You must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician; and

2. You will no longer benefit from standard Medical Care or have chosen to receive hospice care rather than standard care.

Additionally, a family member or friend should be available to provide custodial type care between visits from the Hospice Care Program Provider, if hospice is being provided in the home.

Covered Services under such Hospice Care Program include:

1. Coordinated Home Care;

2. Medical supplies and dressings;

3. Medication;

4. Nursing Services - Skilled and non-Skilled;

5. Occupational Therapy;

6. Pain management services;

7. Physical Therapy;

8. Physician visits;

9. Social and spiritual services; and

10. Respite Care Service.

This plan does not cover Hospice Care benefits for:

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; or

5. Transportation, including, but not limited to, Ambulance Transportation.

Regardless of the above, there may be clinical situations when short episodes of traditional care would be suitable. This may occur even when the patient remains in the hospice setting. While such services are not covered under this "Hospice Care Program" provision, they may be Covered Services under other sections under this Certificate.

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Covered Services in the *Summary of Benefits* section of this Certificate.

Pediatric Palliative Care

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

Important Prior Authorization Requirements

Please see the *Utilization Management and Review* section under this Certificate for information regarding Prior Authorization requirements.

PHYSICIAN AND OTHER PROFESSIONAL SERVICES

This section describes the services and supplies covered by this plan when received from a Physician, or other specified Professional Provider, if the services are Medically Necessary and you receive the services on or after your Coverage Date from a health care Provider who is acting within the scope of his or her license.

In-Network and Out-of-Network Professional Providers are:

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

**Dentists are Out-of-Network Providers, but they will be treated as such for purposes of benefit payment made under this Certificate. They may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.*

The following medical and surgical benefits are subject to the payment levels for *Physicians and Other Professional Services* stated in the *Summary of Benefits* section, and the terms and conditions under this Certificate. Benefits for Covered Services received in a Physician's office are based on the type of service received during your office visit. (The Covered Services have been alphabetized for quick reference.)

A1C Testing

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

Additional Surgical Opinion

This plan provides benefits for a second surgical opinion following a recommendation for elective Surgery. This benefit will be limited to one consultation and a related Diagnostic Service by a Physician.

Upon request, this plan provides benefits for an additional consultation when the need for elective Surgery, in your opinion, is not resolved by the first arranged consultation.

Allergy Injections and Allergy Testing

This plan provides benefits for allergy injections and allergy testing.

Amino Acid-Based Elemental Formulas

This plan provides benefits for amino acid-based elemental formulas for the diagnosis and treatment of:

1. Eosinophilic disorders; or

2. Short-bowel syndrome.

The prescribing Physician must have issued a written order that states such formula is Medically Necessary in order to be eligible for benefits. If you buy the formula at a Pharmacy, the benefits will be at the same benefit payment level as for Other Covered Services described in the *Other Covered Services* section under this Certificate.

Biomarker Testing

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

Blood Glucose Monitors for Treatment of Diabetes

This plan provides benefits for Medically Necessary blood glucose monitors (including non-invasive monitors and monitors for the blind and lancets and lancet devices), if a Physician has provided a written order.

Bone Mass Measurement and Osteoporosis

Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Breast Cancer Pain Medication and Therapy

This plan provides benefits for all Medically Necessary pain medicines and therapy related to the treatment of breast cancer. Pain therapy means, therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

Breast Implant Removal

This plan provides benefits for Medically Necessary breast implant removal for sickness or injury. This benefit does not apply to Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons. For the purpose of this benefit, cosmetic reasons do not include cosmetic Surgery performed as reconstruction resulting from sickness or injury. Please refer to the provision entitled “Mastectomy-Related Services” in the *Special Conditions and Payments* section of this Certificate for additional information.

Breast Reduction Surgery

This plan provides benefits for Medically Necessary breast reduction surgery.

Cardiovascular Disease Management

This plan provides benefits for Medically Necessary cardiovascular disease management.

Chemotherapy

This plan provides benefits for Medically Necessary Chemotherapy.

Chiropractic and Osteopathic Manipulation

This plan provides benefits for Medically Necessary 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.

Cleft Lip and Palate

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

Comprehensive Cancer Testing

This plan provides benefits for Medically Necessary Comprehensive Cancer Testing, including, but not limited to, whole-exome genome testing, whole-genome sequencing, RNA sequencing, tumor mutation burden, and targeted cancer gene panels. This plan also provides benefits for Medically Necessary testing of blood or constitutional tissue for cancer predisposition testing as determined by a licensed Physician.

Consultations

This plan provides benefits for Medically Necessary consultations that are requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition, which requires special skill or knowledge. Benefits are not available for any consultation performed because of a Hospital regulation, or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

This plan provides benefits for Medically Necessary Outpatient self-management training, education and medical nutrition therapy and 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:

1. Physician; or

2. Duly certified, registered or licensed health care Provider with expertise in diabetes management and operating within the scope of his or her license.

Benefits for such health care professionals will be provided at the benefit payment for Other Covered Services described in the *Other Covered Services* section under this Certificate.

Benefits for Physicians will be provided at the benefit payment for Physician Services described later in this benefit section.

This plan provides benefits for regular foot care examinations by a Physician or Podiatrist, and for licensed dietitian nutritionists and certified diabetes educators to counsel diabetics in their home to remove the hurdle of transportation for diabetes patients to receive treatment.

Diagnostic Service

This plan provides benefits for Medically Necessary Diagnostic Services when related to covered Surgery or Medical Care.

Durable Medical Equipment

This plan provides benefits for Medically Necessary:

1. Internal cardiac valves;
2. Internal pacemakers;
3. Mandibular reconstruction devices (not used primarily to support dental prosthesis);
4. Bone screws, bolts, nails;
5. Compression sleeves to prevent or mitigate lymphedema; and
6. Plates and any other internal and permanent devices.

This plan also provides benefits for:

1. The rental (but not to exceed the total cost of equipment); or
2. The purchase of cardiopulmonary monitors or durable medical equipment required for temporary therapeutic use. This is only covered when such equipment is primarily and customarily used to serve a medical purpose.

Early Treatment of a Serious Mental Illness

This plan provides benefits for Medically Necessary treatment of serious Mental Illness in a Child or young adult under age 26, for the following bundled, evidenced-based treatments:

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

Electroconvulsive Therapy

This plan provides benefits for Medically Necessary electroconvulsive therapy.

Epinephrine Injectors

This plan provides benefits for Medically Necessary epinephrine injectors under this benefit section, unless otherwise provided elsewhere under this Certificate.

Experimental/Investigational Treatment

This plan provides benefits for Medically Necessary routine patient care in conjunction with Experimental/Investigational treatments when you have cancer or a terminal condition that according to the diagnosis of your Physician is considered life threatening if:

1. You are a qualified individual participant in an Approved Clinical Trial program; and
2. The services or supplies must be services and supplies that would have been covered if not provided in connection with an Approved Clinical Trial program.

You, or your Physician, should call customer service in advance to find out if a particular clinical trial is qualified. The toll-free telephone number is listed in *Customer Assistance* on the inside front cover of this Certificate.

Fibrocystic Breast Condition

This plan provides benefits for Covered Services that are Medically Necessary and related to fibrocystic breast condition.

Growth Hormone Therapy

This plan provides benefits for Medically Necessary growth hormone therapy.

Hormone Therapy to Treat Menopause

This plan provides benefits for Medically Necessary hormone therapy to treat menopause that has been induced by a hysterectomy.

Human Immunodeficiency Virus (HIV) Screening and Counseling

This plan provides benefits for Medically Necessary HIV screening and counseling, and prenatal HIV testing, when ordered by a Physician, Physician Assistant or an Advanced Practice Registered Nurse, who has a written collaborative agreement with a Physician who authorizes these services. These services include, but are not limited to, orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

Immune Gamma Globulin Therapy (IGTT)

This plan provides benefits for Medically Necessary immune gamma globulin therapy for a Covered Person diagnosed with a primary immunodeficiency when prescribed as Medically Necessary by a Physician. Nothing shall prevent Blue Cross and Blue Shield from applying appropriate utilization review standards to the ongoing coverage of IGTT for persons diagnosed with a primary immunodeficiency. Subject to such utilization review standards:

1. An initial authorization shall be for no less than three months; and

2. Reauthorization may occur every six months thereafter.

For persons who have been in treatment for two years, reauthorization shall be no less than 12 months, or more frequently if required by a Physician.

Immunosuppressant Drugs

This plan pays benefits for Medically Necessary immunosuppressant drugs with a written prescription after an approved Human Organ Transplant.

Long-Term Antibiotic Therapy

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

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

Benefits will also be provided for long-term oral antibiotics used for the treatment of a Tick-Borne Disease under this benefit section, unless otherwise provided elsewhere under this Certificate.

Massage Therapy

This plan provides benefits for Medically Necessary massage therapy.

Medical Care

This plan provides benefits for Medically Necessary Medical Care visits when:

1. You are an Inpatient in:

a. A Hospital;
b. A Substance Use Disorder Treatment Facility;
c. A Residential Treatment Center; or
d. A Skilled Nursing Facility; or

2. You are a patient in:

a. A Partial Hospitalization Treatment Program; or
b. A Coordinated Home Care Program; or

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

Naprapathy Services

This plan provides benefits for Naprapathy Services when rendered by a Naprapath.

Occupational Therapy

This plan provides benefits for Medically Necessary Occupational Therapy when these services are:

1. Rendered by a registered Occupational Therapist; and

2. Under the supervision of a Physician.

Additionally, this therapy must be furnished under a written plan established by a Physician, and reviewed on a regular basis by the therapist and Physician. The plan must be established before treatment begins. This plan must relate to the type, amount, frequency and duration of therapy. This plan must state the diagnosis and anticipated goals. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Occupational Therapy visit maximums, if any, shown in the *Summary of Benefits* under this Certificate.

Orthotic Devices

This plan provides benefits for a Medically Necessary supportive device for the body or a part of the body, head, neck or extremities, including, but not limited to, leg, back, arm and neck braces and those determined by your Provider to be most appropriate for physical activities, such as running, biking, swimming, and lifting. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary.

Pancreatic Cancer Screening

This plan provides benefits for Medically Necessary pancreatic cancer screenings.

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

This plan provides benefits for all Medically Necessary treatment for such disorder or syndrome. This includes coverage for Medically Necessary intravenous immunoglobulin therapy. Immunoglobulin therapy is also known as immune gamma globulin therapy.

Pediatric Neuromuscular, Neurological, or Cognitive Impairment

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

Physical Therapy

This plan provides benefits for Medically Necessary Physical Therapy when:

1. Rendered by a Physician or Physical Therapist; and

2. If the therapy is beyond the scope of the Physical Therapist's License, the Physical Therapist must be under the supervision of a Physician. The Physical Therapy must also be furnished under a written plan established by a Physician and reviewed on a regular basis by the Physical Therapist and the Physician.

The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Physical Therapy visit maximums, if any, shown in the *Summary of Benefits* section under this Certificate.

Prosthetic Appliances

This plan provides benefits for Medically Necessary prosthetic devices, including those determined by your Provider to be most appropriate for physical acitivites, such as running, biking, swimming, and lifting, special appliances and surgical implants when:

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

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

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required, because of wear or change in a patient's condition excluding:

1. Dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders; and

2. Replacement of cataract lenses (when a prescription change is not required).

Pulmonary Rehabilitation Therapy

This plan provides benefits for Medically Necessary Outpatient cardiac/pulmonary rehabilitation services that are provided within six months of a cardiac incident.

Radiation Therapy Treatments

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

Reconstructive Services

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

Speech Therapy

This plan provides benefits for Medically Necessary Speech Therapy. These services must be provided by a licensed Speech Therapist, or a Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits are provided only if Speech Therapy is not the only reason for admission. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Physical Therapy visit maximums, if any, shown in the *Summary of Benefits* section under this Certificate.

Surgery and Related Services

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

1. Surgical removal of complete bony impacted teeth;

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

3. Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

4. Excision of exostoses of the jaws and hard palate (if this procedure is not done in preparation for dentures or other prostheses);

5. Treatment of fractures of facial bone;

6. External incision and drainage of cellulitis;

7. Incision of accessory sinuses, salivary glands or ducts; and

8. Reduction of, dislocation of, or excision of temporomandibular joints.

The following Medically Necessary services are also part of your surgical benefits:

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

2. Anesthesia administered for dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a Child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care; and

3. Anesthesia administered for dental care treatment in a dental office, oral surgeon's office, Hospital or Ambulatory Surgical Facility if (a) you are under age 26, and (b) you have been diagnosed with an Autism Spectrum Disorder or a Developmental Disability.

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

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

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

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

a. It manifested before the age of 22;
b. It is likely to continue indefinitely; and
c. It results in substantial functional limitations in 3 or more of the following areas of major life activity:
    (i) self-care;
    (ii) language;
    (iii) learning;
    (iv) mobility;
    (v) self-direction; and
    (vi) the capacity for independent living

In addition, benefits will be provided for Medically Necessary surgical assistance when performed by:

1. A Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility;

2. A Registered Surgical Assistant or an Advanced Practice Nurse; or

3. A Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.

Sterilization Procedures

Benefits for Covered sterilization procedures and follow-up services will be provided at no charge, when received from a Participating Provider.

Telehealth and Telemedicine Services

This plan provides benefits for Telehealth and Telemedicine Services.

Tobacco Cessation Drugs

This plan provides benefits for tobacco cessation drugs.

Tobacco Use Screening and Smoking Cessation Counseling Services

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

Vaccinations obtained through Pharmacies

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

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

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

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

Vitamin D Testing

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

VIRTUAL VISITS

This plan provides benefits for Covered Services described under this Certificate for the diagnosis and treatment of certain non-emergency medical and behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be done without an in-person office visit for:

1. Primary care;
2. Convenient care;
3. Urgent care;
4. Emergency room care; or
5. Behavioral health care.

Covered Services received through a Virtual Visit must be rendered by a Virtual Provider who has a specific agreement with Blue Cross and Blue Shield to provide Virtual Visits.

Benefits for such Covered Services will only be provided if you receive them through a consultation with a Virtual Provider.

For more information about Virtual Visits, you may visit Blue Cross and Blue Shield's website at www.bcbsil.com or call customer service at the toll-free telephone number on the back of your Identification Card.

Benefits will not be provided for a service you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with Blue Cross and Blue Shield to provide Virtual Visits.

Not all medical or behavioral health conditions are conditions that can or should be treated through Virtual Visits. The Virtual Provider will identify any condition for which treatment by an in-person Provider is necessary.

OTHER COVERED SERVICES

This section describes other services and supplies covered by this plan when received from a Hospital, Physician or other specified Professional Provider. This is regardless of whether the Provider is an In-Network Provider or an Out-of-Network Provider with the plan. For benefits to be available under this section, services must be Medically Necessary, and you must receive such services on or after your Coverage Date from a duly licensed Provider. Covered Services must be within the scope of the Professional Provider's license.

The following Covered Services are subject to the payment levels for Other Covered Services specified in the *Summary of Benefits* section under this Certificate, and all terms and conditions under this Certificate. When you receive these Other Covered Services from an In-Network Provider or an Out-of-Network Provider, benefits will be provided at the payment levels described in the *Summary of Benefits* section under this Certificate for "Outpatient Hospital Services" or "Physicians and Other Professional Services". A listing of In-Network and Out-of-Network Professional Providers is included in the *Physicians and Other Professional Services* section under this Certificate. For your convenience, the Covered Services have been alphabetized for quick reference.

Ambulance Transportation

This plan provides for Ambulance Transportation when your condition is such that an ambulance is Medically Necessary. Benefits will not be provided for long distance trips, or for use of an ambulance because it is more convenient than other transportation.

Blood and Blood Components

This plan provides for the processing, transporting, storing, handling and administration of blood and blood components.

Dental Accident Care

This plan provides for dental services rendered by a Dentist or Physician, limited to sound natural teeth, which are:

1. Required as the result of an accidental injury; and

2. Caused by an external force.

External force means any outside strength producing damages to the dentition and/or oral structures.

Hearing Aids

This plan provides benefits for Medically Necessary Hearing Aids when a Hearing Care Professional prescribes a Hearing Aid to augment communication as follows:

1. One Hearing Aid will be covered for each ear every 24 months;

2. Related services, such as audiological examinations and selection, fitting, and adjustment of ear molds to maintain optimal fit will be covered when deemed Medically Necessary by a Hearing Care Professional; and

3. Hearing Aid repairs will be covered when deemed Medically Necessary.

Hearing Implants

This plan provides benefits for bone anchored hearing aids (cochlear implants).

Human Breast Milk

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

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

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

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

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

5. One or more of the following applies:

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

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

c. The infant has infant hypoglycemia;

d. The infant has congenital heart disease;

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

f. The infant has sepsis; or

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

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

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

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

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

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

5. One or more of the following applies:

a. The Child has spinal muscular atrophy;

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

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

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

Medical and Surgical Dressings, Supplies, Casts and Splints

This plan provides benefits for Medically Necessary medical and surgical dressings, supplies, casts and splints.

Oxygen and Its Administration

This plan provides benefits for Medically Necessary oxygen and its administration.

Private Duty Nursing Service

Benefits for Private Duty Nursing Service will be provided to you as an Inpatient in a Hospital or other health care facility, only when Blue Cross and Blue Shield determines that the services provided are of such a nature or degree of complexity or quantity, that they could not be or are not usually provided by the regular nursing staff of the Hospital or other health care facility.

Benefits for Private Duty Nursing Service will be provided to you in your home, only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care Provider.

No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment uses, and monitoring to home caregivers. It is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.

Important Prior Authorization Requirements

Please see *the Utilization Management and Review* section under this Certificate for information regarding Prior Authorization requirements.

ROUTINE SERVICES

Benefits for the following routine services and supplies will not be subject to any Deductible, Coinsurance, Copayment and/or benefit maximum when such services are received from an In-Network Provider or Participating Pharmacy that is contracted for such service. When you receive these Covered Services from an Out-of-Network Provider, benefits will be provided at the payment levels described in the *Summary of Benefits* section under this Certificate for Outpatient Hospital Services or Physicians and Other Professional Services. In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date. The Covered Services have been alphabetized for quick reference.

Clinical Breast Examinations

Benefits will be provided for, at a minimum, every three years for women at least 20 years of age but less than 40 years of age and annually for women 40 years of age or older for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Colorectal Cancer Screening

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

Diagnostic Colonoscopies

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

Human Papillomavirus Vaccine

Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. (FDA). If you purchase the vaccine at a Pharmacy, benefits will be provided at the benefit payment for *Other Covered Services* described in the *Summary of Benefits*.

Ovarian Cancer Screening

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

Outpatient Contraceptive Services

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

Contraceptive Drugs

Benefits are available for contraceptive drugs and products shown on the *Contraceptive Coverage List* and will not be subject to any Deductible, Coinsurance and/or Copayment when received from a Participating Prescription Drug Provider.

Your share of the cost for all other contraceptive drugs and products will be provided at the benefit payment for Other Covered Services described in the *Other Covered Services* section of this Certificate.

In addition, you may receive coverage for up to a 12-month supply for dispensed contraceptive drugs and products.

Benefits will also be provided for dispensed contraceptive drugs and products when purchased through the Home Delivery Prescription Drug Program. The Home Delivery Prescription Drug Program provides delivery of Covered Drugs directly to your home address. Benefits under the Home Delivery Program are limited to certain contraceptive drugs and products.

Benefits will not be provided for any other Outpatient drugs and/or medicines under this benefit provision or any other benefit section under this Certificate, except as otherwise specified.

If you are unsure whether a Pharmacy is a Participating Pharmacy, or for additional information about the Home Delivery Prescription Drug Program, you may access Blue Cross and Blue Shield's website at www.bcbsil.com or call the customer service toll-free number on your Identification Card.

Your prescribing health care Provider (your “prescriber”), or your authorized representative, may ask for the Drug List or the *Contraceptive Coverage List* exception if your drug is not on (or is being removed from) the Drug List or the *Contraceptive Coverage List* or the drug required as part of step therapy, or the dispensing limit has been found to be (or is likely to be), not right for you or does not work as well in treating your condition. To request this exception, you, your prescriber, or authorized representative, may call the toll-free telephone number on the back of your Identification Card to request a review. Blue Cross and Blue Shield will let you, your prescriber or authorized representative know its coverage decision within 72 hours after receiving your request. If the coverage request is denied, Blue Cross and Blue Shield will let you, your prescriber, or authorized representative, know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial.

If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug your prescriber, or your authorized representative, may ask for an expedited review process. Blue Cross and Blue Shield will let you, your prescriber, or your authorized representative, know its coverage decision within 24 hours after receiving the request for an expedited review. If the coverage request is denied, Blue Cross and Blue Shield will let you, your prescriber, or your authorized representative, know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Please call the toll-free telephone number on the back of your Identification Card if you have any questions.

Diagnostic Mammograms

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

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or pap smear test.

Prostate Cancer Screening

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

Routine Mammograms:

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

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

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

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

Routine Shingles Vaccine

Benefits will be provided for a shingles vaccine approved by the FDA.

Routine Liver Screening

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

PREVENTIVE CARE SERVICES

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

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

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

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

4. With respect to women, such additional preventive care and screenings, not described in item 1. above, as provided for in comprehensive guidelines supported by the HRSA.

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

For purposes of this Preventive Care Services benefit provision, the current recommendations of the USPSTF regarding breast cancer screening, 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 1 through 4 above, may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Blue Cross and Blue Shield website at www.bcbsil.com or contact customer service at the toll-free telephone number on your Identification Card.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, Blue Cross and Blue Shield may use reasonable medical management techniques, including, but not limited to, those related to setting and medical appropriateness to determine coverage.

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

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

1. Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked;

2. Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions;

3. Unhealthy alcohol and drug use screening and counseling;

4. Aspirin use for men and women for prevention of cardiovascular disease for certain ages;

5. Blood pressure screening;

6. Cholesterol screening for adults of certain ages or at higher risk;

7. Colorectal cancer screening for adults over age 45;

8. Depression screening;

9. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease factors for cardiovascular disease;

10. HIV screening for all adults at higher risk;

11. HIV pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition, including baseline and monitoring services;

12. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):

    a. COVID-19;
    b. Diphtheria, Tetanus, Pertussis;
    c. Haemophilus influenze type b (Hib);
    d. Hepatitis A;
    e. Hepatitis B;
    f. Herpes Zoster (Shingles);
    g. Human papillomavirus;
    h. Influenza (Flu shot or Flu mist);
    i. Measles, Mumps, Rubella;
    j. Meningococcal;
    k. MPOX;
    l. Pneumococcal;
    m. RSV; and
    n. Varicella.

13. Obesity screening and counseling;

14. Sexually transmitted infections (STI) counseling;

15. Tobacco use screening and cessation interventions for tobacco users;

16. Syphilis screening for adults at higher risk;

17. Exercise interventions to prevent falls in adults aged 65 and older who are at increased risk for falls;

18. Hepatitis C virus (HCV) screening infection in adults aged 19 to 79 years;

19. Hepatitis B virus screening for persons at high risk for infection;

20. Counseling Children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;

21. Lung cancer screening in adults of age 50 and older who have a 20-pack a year smoking history and currently smoke or have quit within 15 years;

22. Screening for high blood pressure in adults age 18 years or older;

23. Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese;

24. Low to moderate-dose statin for the prevention of cardiovascular disease (for adults aged 40 to 75 years) with:

a. no history or CVD;

b. 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking); and

c. a calculated 10-year CVD risk of 10% or greater;

25. Tuberculin testing for adults 18 years or older who are at risk of tuberculosis;

26. Whole body skin examination for lesions suspicious for skin cancer; and

27. Mental health prevention and wellness visit.

Preventive Care Services for Women (including pregnant women or others as specified):

1. Bacteriuria urinary tract screening or other infection screening for pregnant women;

2. BRCA counseling about genetic testing for women at higher risk and if recommended by a Provider after counseling, genetic testing;

3. Breast cancer chemoprevention counseling for women at higher risk;

4. Breastfeeding comprehensive lactation support and counseling from trained Providers, as well as, access to breastfeeding supplies for pregnant and nursing women. Electric breast pumps are limited to one per benefit period;

5. Cervical cancer screening;

6. Chlamydia infection screening for younger women and women at higher risk;

7. Contraception: Certain FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling;

8. Female and male condoms.

9. Domestic and interpersonal violence screening and counseling for all women;

10. Daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant;

11. Diabetes screening after pregnancy;

12. Gestational diabetes screening for women after 24 weeks pregnant and those at high risk of developing gestational diabetes;

13. Gonorrhea screening for all women;

14. Hepatitis B screening for pregnant women at their first prenatal visit;

15. HIV screening and counseling for women;

16. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older;

17. Osteoporosis screening for women over age 65 and younger women with risk factors;

18. Perinatal depression screening and counseling;

19. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;

20. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users;

21. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened;

22. Sexually transmitted infections (STI) counseling;

23. Syphilis screening for all pregnant women or other women at increased risk;

24. Well-woman visits to obtain recommended preventive services;

25. Urinary incontinence screening;

26. Breast cancer mammography screening, including breast tomosynthesis and, if determined to be Medically Necessary by a Physician, Advanced Practice Nurse or a Physician Assistant, a screening MRI and comprehensive ultrasound;

27. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal;

28. Aspirin use for pregnant woman to prevent preeclampsia;

29. Screening for preeclampsia in pregnant woman with blood pressure measurements throughout pregnancy;

30. Anemia screening, on a routine basis for pregnant women;

31. Behavioral counseling to promote healthy weight gain during pregnancy; and

32. Behavioral counseling to maintain weight or limit weight gain to prevent obesity for women who are aged 40 or older.

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

1. Alcohol and drug use assessment for adolescents;

2. Behavioral assessments for Children of all ages;

3. Blood pressure screenings for Children of all ages;

4. Cervical dysplasia screening for females;

5. Congenital hypothyroidism screening for newborns;

6. Critical congenital heart defect screening for newborns;

7. Depression screening for adolescents;

8. Development screening for Children under age 3, and surveillance throughout childhood;

9. Dyslipidemia screening for Children ages 9-11 and 17-21;

10. Bilirubin screening in newborns;

11. Fluoride chemoprevention supplements for Children without fluoride in their water source;

12. Fluoride varnish to primary teeth of all infants and Children starting at the age of primary tooth eruption;

13. Gonorrhea preventive medication for the eyes of all newborns;

14. Hearing screening for all newborns, Children, and adolescents;

15. Height, weight and body mass index measurements;

16. Hematocrit or hemoglobin screening;

17. Hemoglobinopathies or sickle cell screening for all newborns;

18. HIV screening for adolescents at higher risk;

19. The following immunization vaccines for Children from birth to age 18 (doses, recommended ages, and recommended populations vary):

a. COVID-19;
b. Diphtheria, Tetanus, Pertussis;
c. Diphtheria, Tetanus & Acellular Pertussis;
d. Haemophilus influenzae type b (Hib);
e. Hepatitis A;
f. Hepatitis B;
g. Human papillomavirus (HPV);
h. Inactivated Poliovirus;
i. Influenza (Flu shot or Flu mist);
j. Measles, Mumps, Rubella;
k. Meningococcal;
l. Pneumococcal;
m. Rotavirus;
n. RSV;
o. Varicella.

20. Lead screening for Children at risk for exposure;

21. Autism screening;

22. Medical history for all Children throughout development;

23. Obesity screening and counseling;

24. Oral health risk assessment for younger Children up to ten years old;

25. Phenylketonuria (PKU) screening for newborns;

26. Sexually transmitted infections (STI) prevention and counseling for adolescents;

27. Tuberculin testing for Children at higher risk of tuberculosis;

28. Vision screening for Children and adolescents;

29. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged Children and adolescents;

30. Newborn blood screening;

31. Any other immunization that is required by law for a Child. Allergy injections are not considered immunizations under this benefit provision;

32. Whole body skin examination for lesions suspicious for skin cancer; and

33. Mental health prevention and wellness visit.

The FDA approved contraceptive drugs and devices currently covered under this benefit provision are listed on the *Contraceptive Coverage List.* This list is available on the Blue Cross and Blue Shield website at www.bcbsil.com and/or by contacting customer service at the toll-free telephone number on your Identification Card.

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

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

Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the *Contraceptive Coverage List.* You may, however, have coverage under other sections under this Certificate, subject to any applicable Deductible, Coinsurance, Copayments and/or benefit maximums. The *Contraceptive Coverage List* and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

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

Benefits for vaccinations that are considered preventive care services will not be subject to any Deductible, Coinsurance, Copayments and/or benefit maximum when such services are received from an In-Network Provider or Participating Pharmacy.

Vaccinations that are received from an Out-of-Network Provider, a Non-Plan Provider facility, a Non-Participating Pharmacy, or other vaccinations that are not provided for under this provision, may be subject to the Deductible, Coinsurance, Copayments and/or benefit maximum.

SPECIAL CONDITIONS AND PAYMENTS

This section describes the services and supplies covered under this health plan that are paid the same as your benefits for any other condition.

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

Autism Spectrum Disorder(s)

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

1. Psychiatric care, including diagnostic services;

2. Psychological assessments and treatments;

3. Habilitative or rehabilitative treatments;

4. Therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas:

   a. Self-care and feeding;

   b. Pragmatic, receptive and expressive language;

   c. Cognitive functioning;

   d. Applied behavior analysis (ABA), intervention and modification;

   e. Motor planning; and

   f. Sensory processing.

Please review the "Occupational Therapy, Physical Therapy and Speech Therapy" provisions found in the *Physician and Other Professional Services* section of this Certificate.

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

Cardiac Rehabilitation Services

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

Fertility Preservation Services

Your benefits for fertility preservation services are the same as your benefits for any other condition. Benefits will be provided for Medically Necessary Standard Fertility Preservation Services when a Medically Necessary treatment May Directly or Indirectly Cause Iatrogenic Infertility to a Covered Person.

Habilitative Services

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

1. A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and

2. Treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and

3. Treatment must be Medically Necessary and therapeutic and not Experimental/Investigational.

Human Organ Transplants

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

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

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

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

Benefits will be provided for:

1. Inpatient and Outpatient Covered Services related to the transplant Surgery;

2. The evaluation, preparation and delivery of the donor organ;

3. The removal of the organ from the donor; and

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

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

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

Your benefits under this coverage will begin no earlier than 5 days prior to the transplant Surgery, and shall continue for a period of no longer than 365 days after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.

Transportation and Lodging

If you are the recipient of a 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 one or two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

1. Benefits for lodging will be provided at 80% of the Transplant Lodging Eligible Expense. Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.

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

1. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery;

2. Transportation by air ambulance for the donor or the recipient;

3. Travel time and related expenses required by a Provider;

4. Drugs which are Experimental/Investigational;

5. Drugs which do not have approval of the FDA;

6. Storage fees;

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

8. Meals.

Infertility Treatment

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

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

1. The inability to conceive a Child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman 35 years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining Infertility);

2. A person's inability to reproduce either as a single individual or with a partner without medical intervention; or

3. A licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

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

Benefits for treatments that include oocyte retrievals will be provided only when you have been unable to attain or maintain a viable pregnancy or sustain a successful pregnancy through reasonable, less costly, or medically appropriate Infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless. Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per benefit period. However, if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered per benefit period. These benefits include other Medically Necessary fertility services until you or your surrogate is discharged to regular obstetrical care.

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

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

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

1. Services or supplies rendered to a surrogate after eggs, sperm or embryos have been transferred into the surrogate, non-medical expenses you incur to contract with the surrogate and any other services rendered to a surrogate that are not directly related to treatment of your Infertility;

2. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance. Please note, that benefits may be provided for fertility preservation as described in the "Fertility Preservation Services" provision under this Certificate;

3. Non-medical costs of an egg or sperm donor;

4. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield;

5. Infertility treatments which are deemed Experimental/Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists; and

6. Infertility treatment rendered to your Dependents under age 18.

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

Mastectomy-Related Services

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

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

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge;

4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; and

5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered Cosmetic Surgery.

Maternity Service

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

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

1. The routine Inpatient Hospital nursery charges;

2. One routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the Child or administered anesthesia during delivery; and

3. One Inpatient hearing screening.

(If the newborn Child needs treatment for an illness, injury, congenital defect (including Medically Necessary treatment and care for cleft lip and palate), birth abnormality or a premature birth, benefits will be available for that care from the moment of birth up to the first 31 days; thereafter, you must add the newborn Child to your Family Coverage. You may apply for Family Coverage within 31 days of the date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any Hospital length of stay in connection with childbirth for the mother or newborn Child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from Blue Cross and Blue Shield for prescribing a length of stay less than 48

hours (or 96 hours). Such an earlier discharge may only be provided if there is coverage and availability of a post-discharge Physician office visit or an in-home visit to verify the condition of the infant in the first 48 hours after discharge.

Other Reproductive Health Services

Your coverage includes benefits for abortion care. Benefits for abortion care are the same as your benefits for any other condition.

Mental Illness and Substance Use Disorder Services

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

Outpatient Infusion Therapy

Benefits for certain Outpatient Infusion Therapy may vary depending on whether services are received in a Hospital, an office, an Infusion Suite, or in your home. Your out-of-pocket expenses may be lower when Covered Services for Outpatient Infusion Therapy are received in your home, Provider's office or Infusion Suite instead of a Hospital.

Substance Use Disorder Treatment

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

Detoxification

Covered Services received for detoxification are not subject to the “Substance Use Disorder Treatment” provision specified above. Benefits for Covered Services received for detoxification will be provided at the payment levels described in the *Summary of Benefits* section under this Certificate for “Outpatient Hospital Services” or *“*Physicians and Other Professional Services”.

Bariatric Surgery

Benefits for Covered Services for bariatric Surgery will be provided at the payment levels described in the *Summary of Benefits* section under this Certificate for “Outpatient Hospital Services” or “Physicians and Other Professional Services”.

Temporomandibular Joint Dysfunction and Related Disorders

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

Port-Wine Stain Treatment

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

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician or health care Provider may prescribe certain drugs or medicines as part of your treatment. Your coverage under this Benefit Section includes benefits for drugs and supplies which are self-administered, however, benefits will not be provided for any self-administered drugs dispensed by a Physician or health care Provider. This Benefit Section of your Certificate explains which drugs and supplies are covered and the benefits that are provided for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

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

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

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

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

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

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

Brand Name Drug (Non-Preferred) means a Brand Name Drug that is identified on the Drug List as a Non-Preferred Brand Name Drug. The Drug List is accessible by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

Brand Name Drug (Preferred) means a Brand Name Drug that is identified on the Drug List as a Preferred Brand Name Drug. The Drug List is accessible by accessing the Blue Cross and Blue Shield website at www.bcbsil.com.

Coinsurance Amount means the percentage amount paid by you for each Prescription filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

Compound Drugs means those drugs or inert ingredients that have been measured and mixed by a pharmacist to produce a unique formulation because commercial products either do not exist or do not exist in the correct dosage, size or form.

Copayment Amount means the dollar amount paid by you for each Prescription 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):

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

Drug List means a list of drugs that may be covered under this Benefit Section. A current list is available on our website at https://www.bcbsil.com You may also contact a customer service representative at the toll-free telephone number shown on the back of your Identification Card for more information.

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

1. The charge that the particular Prescription Drug Provider usually charges for Covered Services; or
2. The agreed upon cost between a Participating Pharmacy and a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, whichever is lower.

Generic Drug means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding payment level, Blue Cross and Blue Shield utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. You should know that not all drugs identified as a "generic" by the drug product database, manufacturer, Pharmacy or your Physician will adjudicate as generic. Generic Drugs are listed on the Drug List which is available by accessing the Blue Cross and Blue Shield website at www.bcbsil.com. You may also contact customer service at the toll-free telephone number shown on the back of your Identification Card for more information.

Health Care Practitioner means an Advanced Practice Nurse, Doctor of Medicine, doctor of dentistry, Physician Assistant, doctor of osteopathy, Doctor of Podiatry, or other licensed person with prescription authority.

Legend Drugs means drugs, biologicals, or compounded prescriptions that 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-Participating Pharmacy or Non-Participating Prescription Drug Provider has the meaning set forth in the *Definitions* section under this Certificate.

Participating Pharmacy or Participating Prescription Drug Provider has the meaning set forth in the *Definitions* section under this Certificate.

Pharmacy has the meaning set forth in the *Definitions* section under this Certificate.

Preferred Specialty Pharmacy Provider means a Participating Prescription Drug Provider that has a written agreement with Blue Cross and Blue Shield, or an entity chosen by Blue Cross and Blue Shield, to administer its prescription drug program, to provide Specialty Drugs to you.

Prescription means a written or verbal order from a Health Care Practitioner to a pharmacist for a drug to be dispensed. Prescriptions 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 used to treat complex medical conditions, and are typically given by injection, but may be topical or taken by mouth. In addition, patient support and/or education may be required for these drugs. These drugs often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail pharmacies.

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

ABOUT YOUR BENEFITS

Drug List

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

Positive changes (e.g. adding drugs to the Drug List or drugs moving to a lower payment tier) occur quarterly after review by the committee. Changes to the Drug List that could have an adverse financial impact to you (i.e. drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or prior authorization) occur quarterly or annually. However, when there has been a pharmaceutical manufacturer recall or other safety concern, changes to the Drug List may occur more frequently.

The Drug List and any modifications are available by accessing the Blue Cross and Blue Shield website at www.bcbsil.com, or by calling the customer service toll-free telephone number on your Identification Card. You will be able to determine the Drug List that applies to your benefit plan and whether a particular drug is on the Drug List.

Your prescribing health care Provider, or your authorized representative, may request an exception if your drug is not on (or is being removed from) the Drug List, if the drug requires prior authorization before it may be covered, or if the drug required as part of step therapy has been found to be (or likely to be) not right for you, or does not work as well in treating your condition. To request this exception, your prescribing health care Provider, or your authorized representative, may call

the toll-free telephone number on the back of your Identification Card to request a review. Blue Cross and Blue Shield will let your prescribing health care Provider, (or authorized representative), know its coverage decision within 72 hours after receiving your request. If the coverage request is denied, Blue Cross and Blue Shield will let your prescribing health care Provider, (or authorized representative), know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals and external review found under the *Claim Filing and Appeals Procedures* section under this Certificate.

If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug, your prescribing health care Provider, may request an expedited review by marking the review as an urgent request. Blue Cross and Blue Shield will let you, or your prescribing health care Provider, know its coverage decision within 24 hours after receiving your request for an expedited review. If the coverage request is denied, Blue Cross and Blue Shield will let you, and your prescribing health care Provider, (or authorized representative), know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process found under the *Claim Filing and Appeals Procedures* section under this Certificate. Please call the toll-free telephone number on the back of your Identification Card if you have any questions.

To the extent required by law, and subject to change as described above, all Covered Drugs indicated for the treatment of Substance Use Disorders are subject to the lowest Coinsurance Amount/Copayment Amount for a Generic Drug, Brand Name Drugs or Specialty Drugs, as applicable. If your exception is denied, you may appeal the decision according to the appeals and external exception review process you receive with the denial determination.

Prior Authorization/Step Therapy Requirement

Prior Authorization (PA): Your benefit plan requires prior authorization for certain drugs. This means that your Physician or health care Provider will need to submit a prior authorization request for coverage of these medications and the request will need to be approved before the medication will be covered under the plan. You and your Physician or health care Provider will be notified of the determination. If Medically Necessary criteria is not met, coverage will be denied, and you will be responsible for the full charge incurred.

Step Therapy (ST): Your benefit plan includes a step therapy program. The step therapy program helps manage costs of expensive drugs by redirecting patients, when appropriate, to equally effective alternatives. The program requires that when starting a new drug treatment, you use a prerequisite drug first, when appropriate. If the prerequisite drug is not effective, a targeted drug may then be acquired in the second step. You will be required to pay the applicable Copayment Amount and/or Coinsurance Amount for the targeted drug. Although you may currently be on therapy, your request for a targeted drug may need to be reviewed to determine if the criteria for coverage of further treatment has been met. A documented treatment with a prerequisite drug may be required for continued coverage of the targeted drug.

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 refer to the Drug List by accessing Blue Cross and Blue Shield's website at www.bcbsil.com or call the customer service toll-free telephone number on your Identification Card.

Day Supply

In order to be eligible for coverage under this Benefit Section, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation described in this Benefit Section. Benefits under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day supply, if allowed by your plan benefits. For information about benefits for these drugs, please call the customer service toll-free telephone number located on your Identification Card. However, early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the

predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the Physician or Optometrist. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained. However, you may receive coverage for up to a 12-month supply for dispensed contraceptive drugs and products that are covered under this benefit Section. For additional information about early refills, please see the "Prescription Refills" provision below.

When you obtain Covered Drugs through a retail pharmacy, one Prescription means up to a 34 consecutive day supply of a drug. Certain drugs may be limited to less than a 34 consecutive day supply. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives.

Under the Home Delivery Prescription Drug Program, one Prescription means up to a 90-consecutive day supply of a drug. Certain drugs may be limited to less than a 90-consecutive day supply. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives.

Dispensing Limits

Drug dispensing limits are designed to help encourage medication use as intended by the FDA. Coverage limits are placed on medications in certain drug categories. Limits may include: quantity of covered medication per Prescription, quantity of covered medication in a given time period and coverage only for members within a certain age range. Blue Cross and Blue Shield evaluates and updates dispensing limits quarterly or annually.

If you require a Prescription in excess of the dispensing limit established by Blue Cross and Blue Shield, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. If Medically Necessary criteria is not met, you will be responsible for the full cost of the Prescription beyond what your coverage allows.

Benefits under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

To determine if a specific drug is subject to this limitation, you may refer to Blue Cross and Blue Shield's website at www.bcbsil.com or call the customer service toll-free telephone number on your Identification Card.

Controlled Substances Limitations

If it is determined that you may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary or appropriate, and restrictions may include, but not be limited to, limiting coverage to services provided by a certain Provider and/or Pharmacy and/or quantities and/or days' supply for the prescribing and dispensing of the controlled substance medication. Additional Copayment Amount and/or Coinsurance Amount and any Deductible may apply.

Prescription Refills

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

1. The prescription drugs are covered under this Certificate or have received an exception approval as described under the Drug List provision above;

2. The prescription drugs are maintenance medications and have refill quantities available to be refilled at the time of synchronization;

3. The medications are not Schedule II, III, or IV controlled substances as defined by the Illinois Controlled Substances Act;

4. All utilization management criteria (as described under the Prior Authorization/Step Therapy Requirement provision above) for prescription drugs have been met;

5. The prescription drugs can be safely split into short-fill periods to achieve synchronization; and

6. The prescription drugs do not have special handling or sourcing needs that require a single, designated Pharmacy to fill or refill the Prescription.

When necessary to permit synchronization, Blue Cross and Blue Shield will prorate the Copayment Amount or Coinsurance Amount, on a daily basis, due for Covered Drugs based on the proportion of days the reduced Prescription covers to the regular day supply as described above under the "Day Supply" provision in this Benefit Section.

COVERED SERVICES

Benefits for prescribed Medically Necessary Covered Drugs will be provided if the drug:

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

2. Has been approved by the FDA for at least one indication; and

3. Is recognized by one of the following for the indication(s) of which the drug is prescribed to treat you for a chronic, disabling or Life-Threatening Disease or Condition:

    a. A prescription drug reference compendium approved by the Department of Insurance; or

    b. Substantially accepted peer-reviewed medical literature.

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

Injectable Drugs

Benefits will be provided for Medically Necessary injectable drugs which are self-administered, requiring a written prescription by federal law, including but not limited to epinephrine injectors. Benefits will not be provided under this Benefit Section for any self-administered drugs dispensed by a Physician or health care Provider.

Intranasal Opioid Reversal Agent

Benefits will be provided for at least one intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50MME or higher.

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

Immunosuppressant Drugs

Benefits will be provided for Medically Necessary immunosuppressant drugs with a written prescription after an approved Human Organ Transplant.

Fertility Drugs

Benefits will be provided for Medically Necessary fertility drugs in connection with the diagnosis and/or treatment of Infertility with a written prescription.

Contraceptive Drugs

Benefits will be provided for contraceptive drugs and products shown on the *Contraceptive Coverage List* and will not be subject to any Deductible, Coinsurance Amount and/or Copayment Amount when received from a Participating Pharmacy Provider. You may access the Blue Cross and Blue Shield website at www.bcbsil.com for more information.

Your share of the cost for all other contraceptive drugs and products will be as shown under the *Outpatient Prescription Drug Program-Summary of Benefits* section under this Certificate.

Diabetic Supplies for Treatment of Diabetes

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

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

Abortifacients

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

Hormonal Therapy for Gender Dysphoria

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

HIV Post-Exposure Prophylaxis

Benefits will be provided at no charge for FDA-approved HIV post-exposure prophylaxis drugs, including FDA-approved drugs prescribed for off-label use, when obtained from a Participating Pharmacy, and for follow-up services, when obtained from a Participating Provider.

Vaccinations obtained through Pharmacies

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

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

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

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

Cancer Medications

Benefits will be provided for orally administered cancer medications, or self-injected cancer medications that are used to treat cancer when a particular legend drug has been shown effective for the treatment of that specific type of cancer and if proper documentation is provided, even though that legend drug may not have FDA-approval for that type of cancer. The drug must have been shown to be effective for the treatment of that particular cancer according to the American Hospital Formulary Service Drug Information; National Comprehensive Cancer Network's Drugs & Biologics Compendium; Thomson Micromedex's Drug Dex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services. Your Deductible, Copayment Amount, or Coinsurance Amount, if any will not apply to orally administered cancer medications when received from a Participating Pharmacy. Coverage of prescribed orally administered cancer medications when received from a non-Preferred Specialty Pharmacy Provider or Non-Participating Pharmacy Provider will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

Self-Administered Cancer Medications

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

Topical Anti-Inflammatory Acute and Chronic Pain Medication

Benefits will be provided for Topical anti-inflammatory medication, including but not limited to Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain.

Opioid Antagonists

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

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

Opioid Medically Assisted Treatment

Benefits will be provided for Buprenorphine or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder.

Specialty Drugs

Benefits will be provided for Specialty Drugs as described under the *Specialty Pharmacy Program*.

Long-Term Antibiotic Therapy

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

Benefits will also be provided for oral antibiotics under this section of the Certificate.

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

Oncology Split Fill Program

If this is your first time using select medications (e.g., cancer medications) or you have not filled one of these medications within 120 days, you may only be able to receive a partial fill (14-15 day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. If you receive a partial fill your cost-share may be adjusted to align with the number of pills dispensed. If the medication is working for you and your Physician wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit https://www.bcbsil.com/rx-drugs/pharmacy/programs-other-members program website. Please be advised these lists are subject to change without notice.

Prenatal Vitamins

Benefits will be provided for prenatal vitamins, when prescribed by a Physician or Advanced Practice Nurse.

Hormone Therapy to Treat Menopause

This plan provides benefits for Medically Necessary hormone therapy to treat menopause that has been induced by a hysterectomy.

Vaginal Estrogen

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

SELECTING A PHARMACY

Participating Pharmacy

When you choose to go to a Participating Pharmacy:

1. Present your Identification Card to the pharmacist along with your Prescription;
2. Provide the pharmacist with the birth date and relationship of the patient;
3. Pay the applicable Deductible, if any; and
4. Pay the appropriate Copayment Amount and/or Coinsurance Amount (and other amounts owed by you under this Certificate) for each Prescription filled or refilled and the pricing difference when it applies to the Covered Drug you receive. The difference in cost between the brand name drug and its generic equivalent will not be applied toward the as the Participating Pharmacies have agreed to accept as payment in full the lesser of:

a. The Billed Charges; or

b. The Eligible Charge; or

c. The amount that you are responsible for as described under the *Outpatient Prescription Drug Program – Summary of Benefits* section under this Certificate.

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

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access Blue Cross and Blue Shield's website at www.bcbsil.com or call the customer service toll-free telephone number on your Identification Card.

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

Non-Participating Pharmacy

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

1. Less the amount for which you are responsible as described under the *Outpatient Prescription Drug Program – Summary of Benefits* section under this Certificate.

Please refer to the provision entitled "Filing Outpatient Prescription Drug Claims" later in this Benefit Section for additional information on how to file outpatient prescription drug Claims.

Home Delivery Prescription Drug Program

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

Some drugs may not be available through the Home Delivery Prescription Drug Program. For a list of Maintenance Drugs or if you have any questions about the Home Delivery Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the home delivery order form, you may access Blue Cross and Blue Shield's

website at www.bcbsil.com, or call the customer service toll-free telephone number on your Identification Card. Please mail the completed form, your Prescription and payment to the address indicated on the form.

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

When you obtain Maintenance Drugs through the Home Delivery Prescription Drug Program, benefits will be provided according to the Home Delivery Prescription Drug Program payment provisions described in the *Outpatient Prescription Drug Program – Summary of Benefits* section under this Certificate.

For information about the Home Delivery Prescription Drug Program, contact the customer service using the toll-free telephone number on the back of your Identification Card or visit www.bcbsil.com.

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

Specialty Pharmacy Program

The Specialty Pharmacy Program provides delivery of medications directly to your Health Care Practitioner, administration location or to your home if you are undergoing treatment for a complex medical condition. To determine which drugs are Specialty Drugs or to locate a Specialty Pharmacy Provider, you should refer to the Drug List by accessing the Blue Cross and Blue Shield website at www.bcbsil.com or call the customer service toll-free telephone number on your Identification Card.

The Specialty Pharmacy Program includes:

1. Coordination of coverage between you, your Health Care Practitioner and the Plan;
2. Educational materials about the patient's particular condition and information about managing potential medication side effects;
3. Syringes, sharp containers, alcohol swabs and other supplies with every shipment of FDA approved self-injectable medications; and
4. Access to a pharmacist 24/7, 365 days a year for general health information.

In order to receive maximum benefits for Specialty Drugs, you must obtain the Specialty Drugs from a Preferred Specialty Pharmacy Provider. When you obtain Specialty Drugs from a Preferred Specialty Pharmacy Provider, benefits will be provided according to the payment provisions indicated in the *Outpatient Prescription Drug Program – Summary of Benefits* section under this Certificate for a Participating Pharmacy.

Please refer to the *Outpatient Prescription Drug Program – Summary of Benefits* section under this Certificate for additional information regarding your payment obligations if you obtain Covered Specialty Drugs from a non-preferred Specialty Pharmacy Provider.

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

Meds Your Way™

MedsYourWay™ ("MedsYourWay") may lower your out-of-pocket costs for select Covered Drugs purchased at select in-network retail pharmacies. MedsYourWay is a program that automatically compares available drug discount card prices and prices under your benefit plan for select Covered Drugs and establishes your out-of-pocket cost to the lower price

available. At the time you submit or pick up your Prescription, present your BCBSIL Identification Card to the pharmacist. This will identify you as a participant in MedsYourWay and allow you the lower price available for select Covered Drugs.

The amount you pay for your Prescription will be applied, if applicable, to your Deductible and out-of-pocket maximum. Available select Covered Drugs and drug discount card pricing through MedsYourWay may change occasionally but your cost with available select covered drugs through MedsYourWay will never be higher than the listed cost share on the schedule for the specific tier the drug is listed under. Certain restrictions may apply and certain Covered Drugs or drug discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount for select Covered Drugs depending upon which retail pharmacy is utilized. For additional information regarding MedsYourWay, please contact a Customer Service Representative at the toll-free telephone number on the back of your Identification Card. Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting your Customer Service Representative at the toll-free telephone number on the back of your Identification Card.

YOUR COST

Deductible

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

Out-of-Pocket Expense Limit

If you have Family Coverage and your out-of-pocket expense for outpatient prescription drugs and diabetic supplies equals the amount described in the *Outpatient Prescription Drug Program – Summary of Benefits* section under this Certificate during one benefit period, then, for the rest of the benefit period, all other family members will have benefits provided at 100% of the Eligible Charge. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

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

BENEFIT PAYMENT FOR PRESCRIPTION DRUGS

As shown in the *Outpatient Prescription Drug Program – Summary of Benefits* section under this Certificate.

- Tier 1 - includes mostly Generic Drugs and may contain some Brand Name Drugs.
- Tier 2 - includes mostly Brand Name Drugs (Preferred) and may contain some Generic Drugs.
- Tier 3 - includes mostly Brand Name Drugs (Non-Preferred) and may contain some Generic Drugs.

The applicable cost-sharing (by tier) and the cost difference between the generic and brand will never exceed the overall actual price of the drug.

To obtain additional information about your benefits for a drug, visit the Blue Cross and Blue Shield website at www.bcbsil.com and log in to Blue Access for Members℠ (BAM) or call the toll-free telephone number on the back of your Identification Card.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits for outpatient prescription drugs. This is primarily true when you did not receive an Identification Card, the Pharmacy was unable to transmit a Claim, or you received benefits from a Non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a prescription drug Claim form. These are also available by accessing the Blue Cross and Blue Shield website at www.bcbsil.com. Claim forms can be accessed by selecting Form Finder under the Member Services tab or you may also call the customer service toll-free telephone number on the back of your Identification Card to request a paper Claim form;

2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized; and

3. Mail the completed Claim form with attachments to:

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

In any case, Claims should be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

EXCLUSIONS

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

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

2. Non-FDA approved drugs.

3. Drugs which do not by law require a Prescription from a Provider or Health Care Practitioner (except insulin, insulin analogs, insulin pens, prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs or covered devices for which no valid Prescription is obtained.

4. Devices, “Technologies, and/or Durable Medical Equipment of any type (even though such devices may require a Prescription Order) such as, but not limited to, therapeutic devices, artificial appliances, “digital health technologies and/or applications,” or similar devices (except disposable hypodermic needles and syringes for self-administered injections).

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

6. Administration or injection of any drugs.

7. Vitamins (except those prenatal vitamins, when prescribed by a Physician or Advanced Practice Nurse, and those which by law require a Prescription and for which there is no non-prescription alternative).

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

9. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the course and scope of employment whether or not benefits are, or could upon proper Claim be, provided under the Workers' Compensation law.

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

11. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, except as specifically mentioned under this Certificate.

12. Drugs dispensed in quantities in excess of the day supply amounts stipulated under this Benefit Section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any Prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner, or by law, or any drugs or medicines dispensed in excess of the amount or beyond the time period allowed by law.

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

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

15. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of your Identification Card.

16. 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.

17. 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.

18. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

19. Prescription for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined.

20. Athletic performance enhancement drugs.

21. Allergy serum and allergy testing materials.

22. Non-self-administered injectable drugs.

23. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit benefits to only certain therapeutic equivalents/therapeutic alternatives available. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your benefit, the drug purchased will not be covered under any benefit level.

24. Non-sedating antihistamine drugs and combination medications containing a non-sedating antihistamine and decongestant.

25. Drugs prescribed for the treatment of heartburn, gastroesophageal reflux disease (GERD) or acid reflux.

26. Brand-name proton pump inhibitors.

27. Compound Drugs.

28. Drugs determined to have inferior efficacy or significant safety issues.

29. Medications in depot or long acting formulations that are intended for use longer than the covered days' supply amount.

30. Devices and pharmaceutical aids.

31. Repackaged medications and institutional packs and drugs which are repackaged by anyone other than the original manufacturer.

32. Surgical supplies.

33. Ostomy products.

34. Diagnostic agents (except diabetic testing supplies or test strips).

35. General anesthetics.

36. Bulk powders.

37. New-to-market FDA-approved drugs that are subject to review by Prime Therapeutics Pharmacy & Therapeutic (P&T) Committee prior to coverage of the drug.

EXCLUSIONS—WHAT IS NOT COVERED

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

1. Services that are not Medically Necessary.

2. Hospitalization or any health care services and supplies which are not Medically Necessary.

3. Services or supplies that are not specifically mentioned under this Certificate.

4. Services or supplies for any illness or injury arising out of, or in the course of, employment for which benefits are available under any Workers' Compensation Law, or other similar laws, whether or not you make a Claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation, and are employed by the corporation, and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

5. Services or supplies that are furnished to you by the local, state or federal government, and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare), whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code, 305 ILCS 5/5-1 et seq., or 5/6-1 et seq., or similar legislation of any state, and benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

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

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

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

9. Custodial Care Service.

10. Long Term Care Service.

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

12. Inpatient Private Duty Nursing Service.

13. Routine physical examinations, unless otherwise specified under this Certificate.

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

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

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

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

18. Special braces, splints, specialized equipment, appliances, ambulatory apparatus, medical equipment and battery implants, except as specifically mentioned under this Certificate.

19. Services or supplies for:

a. Intersegmental traction;

b. All types of home traction devices and equipment;

c. Vertebral axial decompression sessions;

d. Surface EMGs;

e. Spinal manipulation under anesthesia;

f. Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron;

g. Balance testing through computerized dynamic posturography sensory organization test.

20. Blood derivatives that are not classified as drugs in the official formularies.

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

22. Treatment of flat foot conditions, prescriptions for supportive devices for such conditions, and the treatment of subluxations of the foot.

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

24. Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet-rich plasma.

25. Treatment of tissue damage or disease in any location with platelet-rich plasma.

26. Immunizations, unless otherwise specified under this Certificate.

27. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned under this Certificate.

28. Maintenance Care.

29. Habilitative Services that are solely educational in nature or otherwise paid under state or federal laws for purely educational services, except as they relate to Autism Spectrum Disorder(s).

30. Hearing Aids or examinations for the prescription or fitting of Hearing Aids, unless otherwise specified under this Certificate. Bone anchored Hearing Aids, cochlear implants and Hearing Aids for covered persons under the age of 18 may be covered as described under the *Other Covered Services* section under this Certificate.

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

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

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

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

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

36. Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

37. Testing of:

a. Blood for measurement of levels of: Lipoprotein a small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels;

b. Urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover;

c. Cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby(premature ruptured membranes);

d. Allergen specific IgG measurement.

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

39. The following psychological/neuropsychological testing and psychotherapy services:

a. Education testing;

b. Employer/government mandated testing;

c. Testing to determine eligibility for disability benefits;

d. Testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court mandated testing);

e. Testing for vocational purposes (e.g., interest inventories, work related inventories, and career development);

f. Services directed at enhancing one’s personality or lifestyle;

g. Vocational or religious counseling;

h. Activities primarily of an educational nature;

i. Music or dance therapy; and

j. Bioenergetic therapy.

40. Any service or supplies from more than one Provider on the same day(s) to the extent benefits were duplicated.

41. Trauma or wilderness programs for behavioral health or Substance Use Disorder Treatment.

42. Any related services to a non-covered service except for routine patient care for participants in an Approved Clinical Trial. Related services are:

a. Services in preparation for the non-covered service;

b. Services in connection with providing the non-covered service;

c. Hospitalization required to perform the non-covered service; or

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

43. This plan does not cover cannabis. Cannabis means all parts of the plant genus cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.

44. Acupuncture, whether for medical or anesthesia purposes, dry needling, or trigger-point acupuncture.

45. Services and supplies rendered by an Acupuncturist.

46. Behavioral health services provided at behavior modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes, except for Covered Services provided by appropriate Providers as defined in this Certificate.

47. Any of the following applied behavior analysis (ABA) related services:

a. Services with a primary diagnosis that is not Autism Spectrum Disorder;

b. Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of "Qualified ABA Provider' in the *Definitions section* under this Certificate;

c. Activities primarily of an educational nature;

d. Shadow or companion services; and

e. Any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

Some laboratory services are not covered by your Plan. The following laboratory services are not covered:

1. Allergen Testing:

a. Routine re-testing for confirmed allergies to the same allergies except in children and adolescents with positive food allergen results to monitor for food allergy resolution; or

b. The Antigen Leukocyte Antibody test (ALCAT); or

c. In-vitro testing of allergen specific IgG or non-specific IgG, IgA, IgM, and/or IgD in the evaluation of suspected allergy; or

d. Basophil Activation flow cytometry testing for measuring hypersensitivity to allergens; or

e. In-vitro allergen testing using bead-based epitope assays; or

f. In-vitro testing of allergen non-specific IgE;

2. Cardiovascular Disease Risk Assessment Testing:

a. High-sensitivity C-Reactive Protein except when a risk-based treatment decision is not certain after having a quantitative risk assessment using American College of Cardiology/American Heart Association (ACC/AHA) calculator to calculate 10-year risk of Cardiovascular disease CVD; or

b. High-sensitivity C-Reactive Protein as a screening test for the general population or for monitoring response to therapy; or

c. High-sensitivity cardiac troponin T for cardiovascular risk assessment and stratification in the outpatient setting; or

d. Homocysteine testing for cardiovascular disease risk assessment screening, evaluation and management; or

e. Novel Cardiovascular Biomarkers such as measurement of novel lipid and non-lipid biomarkers as an add on to LDL cholesterol in the risk assessment of cardiovascular disease; or

f. Cardiovascular risk panels, consisting of multiple individual biomarkers intended to assess cardiac risk (other than simple lipid panels); or

g. Serum Intermediate Density Lipoprotein as an indicator of cardiovascular disease risk; or

h. Measurement of lipoprotein-associated phospholipase as an indicator of risk of cardiovascular disease; or

i. Measurement of secretory type II phospholipase in the assessment of cardiovascular risk for all indications; or

j. Measurement of long-chain omega-3 fatty acids in red blood cell membranes, including but not limited to its use as a cardiac risk factor; or

k. All other tests for assessing cardiovascular health disease risk;

3. Cervical Cancer Screening:

a. Cervical cancer screening and testing for HPV more than one time per calendar year when:

i. Testing for high-risk strains of HPV-16 and HPV-18 unless both cytology negative and HPV positive co-testing criteria are present; or

ii. Testing on individuals that have no history of cervical cancer or pre-cancer and that do not have a uterus and cervix; or

iii. Inclusion of low-risk strains of HPV in co-testing; or

b. Other technologies are used for cervical cancer screening;

4. Drug testing: Except where testing is rendered in an urgent/emergency situation or as a component of routine physical/medical exam or related to surgery or medical care, drug testing is not covered in an outpatient setting in the following situations:

a. Testing to confirm the presence and/or amount of drugs in your system when laboratory-based definitive drug testing is requested without any prior screening test results, or when laboratory-based definitive drug testing is requested for larger than seven drug class panels; or

b. Use of proprietary drug tests such as CareView360; or

c. Specific validity testing, including, but not limited to urine specific gravity, urine creatinine, Ph, urine oxidant level, and genetic identify testing are included in the panel test – these tests will not be covered if submitted individually and when a urine panel test was also ordered at the same time; or

d. Testing for any American Medical Association definitive drug class codes; or

e. Same-day testing for the same drug or metabolites from two different samples (e.g., both a blood and a urine specimen); or

f. Testing of samples with abnormal validity tests; or

g. Drug testing for patients in a facility setting (inpatient or outpatient) are not separately covered, as they are included in the daily charge at the facility; or

h. Both qualitative (type of drug) testing and presumptive (verification of presents of drugs) testing on the same specimen;

5. Folate Testing:

a. Measurement of red blood cell (RBC) folate; or

b. Measurement of serum folate concentration unless the individual is has been diagnosed with megaloblastic or macrocytic anemia and those conditions do not resolve after folic acid treatment; or

c. Folate receptor autoantibody testing;

6. Hemoglobin A1c: Hemoglobin A1c testing in the following situations:

a. If an individual has had a blood transfusion in the last 120 days; or

b. If an individual has a condition associated with increased red blood cell turnover; or

c. If an individual is also being measured for fructosamine;

7. Iron Homeostatis and Metabolism:

a. Ferritin or transferrin measurement, including transferrin saturation, as a screening test in asymptomatic individuals; or

b. Serum hepcidin testing, including immunoassays; or

c. GlycA testing to measure or monitor transferrin or other glycosylated proteins;

8. Pancreatic Enzyme Testing:

a. As part of an ongoing assessment of therapy for acute pancreatitis; or

b. To determine the prognosis of pancreatitis; or

c. To determine the severity or progression of pancreatitis; or

d. More than once per visit; or

e. For the diagnosis, prognosis, or severity of chronic pancreatitis; or

f. As part of an ongoing assessment or therapy of chronic pancreatitis; or

g. In asymptomatic nonpregnant individuals during general exam without abnormal findings; or

h. Measurement of serum or urine trypsin/trypsinogen/TAP (trypsinogen activation peptide) for the diagnosis, assessment, prognosis and/or determination of severity of acute pancreatitis; or

i. For the diagnosis, assessment, prognosis, and/or determination of severity of acute pancreatitis, measurement of the following biomarkers is not covered:

i. C-Reactive Protein (CRP); or

ii. Interleukin-6 (IL-6); or

iii. Interleukin-8 (IL-8); or

iv. Proclcitonin; or

j. Measurement of urinary amylase concentration for the initial diagnosis of acute pancreatitis for individuals presenting with signs and symptoms of acute pancreatitis;

9. Thryoid Disease:

a. Testing of reverse T3, T3 uptake and total T4 in individuals with no signs or symptoms consistent with hypothyroidism and who are not at high risk for thyroid disease; or

b. Measurement of total T3 (TT3) and/or free T3 (fT3) for the assessment of hypothyroidism; or

c. Measurement of total or free T3 level to assess levothyroxine in hypothyroid individuals; or

d. Testing in asymptomatic nonpregnant individuals for thyroid dysfunction during a general exam without abnormal findings;

10. Vitamin B12:

a. Testing or screening for a Vitamin B12 deficiency in a healthy, asymptomatic individual; or

b. Hynocysteine or holotranscobalamin testing to screen for or to confirm a Vitamin B12 deficiency; or

c. Vitamin B12 testing within three (3) months of beginning treatment for a B12 deficiency;

11. Vitamin D Testing: Routine screening for Vitamin D deficiency with serum testing in individuals who do not present with Vitamin D deficiency risk factors. Risk factors for Vitamin D deficiency include, but are not limited to:

a. Having osteoporosis or other bone-health problems;

b. Having conditions that affect fat absorption including celiac disease or weight loss surgery;

c. Routinely taking medications that interfere with vitamin D activity, including anticonvulsants and glucocorticoids;

d. Beneficiaries aged 55 and older;

e. Having a darker skin color;

f. Inadequate sunlight exposure;

g. Being obese;

h. Previous diagnosis of diabetes or kidney disease; and

i. Exhibiting poor muscle strength or constant tiredness.

COORDINATION OF BENEFITS AND REIMBURSEMENT

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. Coordination of Benefits (COB) does not apply to the *Outpatient Prescription Drug Program* Benefit Section.

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

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

Benefit Program means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

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

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

Each contract or other arrangement under 1 or 2 above, is a separate benefit program. Also, if an arrangement has two parts and COB rules apply, only to one of the two above, each of the parts is a separate Benefit Program.

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

Primary Program or Secondary Program means the order of payment responsibility as determined by the order of benefit determination rules.

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

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

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

ORDER OF BENEFIT DETERMINATION

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

1. The other Benefit Program has rules coordinating its benefits with those of this Benefit Program; and

2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's benefits be determined before those of the other Benefit Program.

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

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

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

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

2. **Dependent Child if Parents not Separated or Divorced**: Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same Child as a Dependent of different persons, (i.e., "Parent").

a. The benefits of the Benefit 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 program which covered the other parent for a shorter period of time.

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

3. **Dependent Child if Parents Separated or Divorced:** If two or more Benefit Programs cover a person as a Dependent Child of divorced or separate parents, benefits for the Child are determined in this order:

a. First, the Benefit Program of the parent with physical custody of the Child;

b. Then, the Benefit Program of the spouse of the parent with physical custody of the Child; and

c. Finally, the Benefit Program of the parent not having physical custody of the Child.

However, if the specific terms of a court decree (order) 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

actual knowledge of the court decree (order). It is the obligation of the person claiming benefits to notify Blue Cross and Blue Shield and, upon its request, to provide a copy of the court decree.

4. **Dependent Child if Parents Share Joint Custody**: If the specific terms of a court decree (order) state that the parents shall share joint custody, without designating that one of the parents is responsible for the health care expenses of the Child, the Benefit Programs covering the Child shall follow the order of benefit determination rules outlined in 2 above.

5. **Young Adult as a Dependent**: For a Dependent Child who has coverage under either or both parents' plans and also has his/her own coverage as a Dependent under a spouse's plan, rule 8, "Length of Coverage" applies. In the event the Dependent's Child coverage under the spouse's plan began on the same date as the Dependent's Child 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's Child parent or parents and the Dependent's spouse.

6. **Active or Inactive Employee**: The benefits of 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 rule, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

The benefits of this Benefit Program will be reduced when:

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

REIMBURSEMENT

If you or one of your covered Dependents incur expenses for sickness or injury that occurred due to the negligence of a third-party and benefits are provided for Covered Services described under this Certificate, you agree:

1. Blue Cross and Blue Shield has the right to reimbursement for all benefits Blue Cross and Blue Shield provided from any and all damages collected from the third-party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative, as a result of that sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which Blue Cross and Blue Shield has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.
2. Blue Cross and Blue Shield is assigned the right to recover from the third-party, or his or her insurer, to the extent of the benefits Blue Cross and Blue Shield provided for that sickness or injury.

Blue Cross and Blue Shield shall have the right to first reimbursement out of all funds you, your covered Dependents or your legal representative, are or were able to obtain for the same expenses for which Blue Cross and Blue Shield has provided benefits as a result of that sickness or injury.

You are required to furnish and provide any information or assistance or provide any documents that Blue Cross and Blue Shield may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

ELIGIBILITY, ENROLLMENT AND TERMINATION INFORMATION

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

1. Meet the definition of an Eligible Person as specified in your Group Policy;

2. Have applied for this coverage;

3. Have received a Blue Cross and Blue Shield Identification Card;

4. Live within Blue Cross and Blue Shield of Illinois' service area; and

5. Reside or live in the geographic network service area served by Blue Cross and Blue Shield for this benefit program. You may call customer service at the toll-free telephone number shown on the back of your Identification Card to determine if you are in the network service area or log on to the website at www.bcbsil.com.

If you meet this description of an Eligible Person and comply with the other terms and conditions of this Certificate, you are entitled to the benefits of this program.

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 factor. You will not be discriminated against for coverage under this Certificate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Certificate that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

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

Your Totally Disabled Dependents will be considered eligible Dependents under this Certificate, if such Dependents meet the description of an eligible family member as specified in the "Family Coverage" provision of this section.

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

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

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

If you have Family Coverage, your health care expenses for Covered Services and those of your enrolled spouse, party to a Civil Union, Domestic Partner and/or your spouse's, party to a Civil Union's enrolled Children who are under age 26 will be covered. The provisions under this Certificate that pertain to a spouse also apply to a party of a Civil Union.

Your enrolled Domestic Partner and his/her enrolled Children who have not attained the limiting age stated above will be covered. Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions under this Certificate that pertain to a spouse also apply to a Domestic Partner.

In addition, enrolled unmarried Children will be covered when under the age of 30 if they:

1. Live within the Network Service Area for this Certificate; and

2. Have served as an active or reserve member of any branch of the Armed Forces of the United States; and

3. Have received a release or discharge (other than a dishonorable discharge).

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

1. The Dependent is enrolled under the Certificate on the basis of being a student at a postsecondary educational institution; and

2. The Dependent was covered immediately before the first day of the Medically Necessary leave of absence or other change in enrollment; and

3. The Dependent Child's treating Physician provides to Blue Cross and Blue Shield a written certification stating that the Child is suffering from a serious illness or injury and that the leave of absence or other change in enrollment is Medically Necessary.

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

1. One year after the first day of the Medically Necessary leave of absence or other change in enrollment; or

2. The date on which such coverage would otherwise terminate under the terms of this Certificate.

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

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

Any newborn Children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted. For further information regarding the coverage of a newborn Child see the "Applying for Coverage" provision under this section below.

Any Children who are under your legal guardianship or who are in your custody under an interim court decree (order) prior to the 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 decree (order) to provide health coverage, those Children will be covered.

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

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

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated at the beginning of this section and you are eligible for Medicare and not affected by the "Medicare Secondary Payer" (MSP) laws as described below, the benefits described under this Certificate apply to you, your spouse and covered Dependent Children (if he or she is also eligible for Medicare and not affected by the MSP laws). Your benefit payments under this Certificate will be determined according to the rules described in the *Coordination of Benefits* section under this Certificate.

A series of federal laws collectively referred to as the "Medicare Secondary Payer" (MSP) laws, regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, Dependent Children. This provision does not apply to a party of a Civil Union with the Eligible Person, the Domestic Partner of the Eligible Person or their Children.

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

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

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

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

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

YOUR MSP RESPONSIBILITIES

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

YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD

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

NOTIFICATION OF ELIGIBILITY CHANGES

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

APPLYING FOR COVERAGE

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

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

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

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

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

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

This "Annual Open Enrollment Period" provision is subject to change by Blue Cross and Blue Shield 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, Domestic Partner 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" provision.

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

Special Enrollment Events:

1. You gain or lose a Dependent or become a Dependent through marriage, becoming a party to a Civil Union or establishment of a Domestic Partnership. New coverage for you and/or your eligible spouse, party to a Civil Union, Domestic Partner 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. If you apply any later than 31 days from the qualifying event date, coverage for your spouse, party to a Civil Union, Domestic Partner and/or Dependents will be effective no later than the first day of the following month.

2. You gain or lose a Dependent through birth, placement of a foster Child, adoption or placement of adoption or court-ordered Dependent coverage. New coverage for you and/or your eligible spouse, party to a Civil Union or Domestic Partner 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 Blue Cross and Blue Shield in accordance with the provisions of the court decree (order).

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

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

This “Special Enrollment Periods/Effective Date of Coverage” provision is subject to change by Blue Cross and Blue Shield 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” provision.

1. Loss of eligibility as a result of:

a. Legal separation, divorce or dissolution of a Civil Union or a Domestic Partnership;

b. Cessation of dependent status (such as attaining the limiting age to be eligible as a Dependent Child under this Certificate;

c. Death of an Eligible Person;

d. Termination of employment, or reduction in the number of hours of employment;

2. Loss of coverage through an HMO in the individual market because you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or Dependents no longer reside or live in the Network Service Area;

3. Loss of coverage through an HMO, or other arrangement, in the group market because you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or Dependents no longer reside or live in the Network Service Area, and no other coverage is available to you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or Dependents;

4. You incur a claim that would meet or exceed a lifetime limit on all benefits;

5. Loss of coverage due to a policy no longer offering benefits to the class of similarly situated individuals that include you;

6. Your employer ceases to contribute towards your and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or Dependents' coverage (excluding COBRA continuation coverage); or

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), including proof of such event and remittance of the appropriate premiums, in accordance with the guidelines as established by Blue Cross and Blue Shield. Your spouse, party to a Civil Union, Domestic Partner and other Dependents are not eligible for a special enrollment period if your Group does not cover Dependents.

This "Special Enrollment Periods" provision is subject to change by Blue Cross and Blue Shield and/or applicable law, as appropriate.

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

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

1. Marriage.

2. Birth, adoption or placement for adoption of a Child.

3. Obtaining legal guardianship of a Child.

4. Becoming party to a Civil Union.

5. Establishment of a Domestic Partnership.

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

   This includes, but is not limited to, loss of coverage due to:
   a. Legal separation, divorce, dissolution from a Civil Union, cessation of Dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;
   b. In the case of HMO coverage, coverage is no longer provided because an individual no longer resides in the service area, or the HMO no longer offers coverage in the HMO service area in which the individual resides;
   c. Reaching a lifetime limit on all benefits in another group health plan;

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

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

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

7. Termination of employer contributions towards your or your Dependent's other coverage.

8. Exhaustion of COBRA continuation coverage or state continuation coverage.

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

1. Marriage.

2. Birth, adoption, or placement of adoption of a Child.

3. Obtaining legal guardianship of a Child.

4. Becoming party to a Civil Union.

5. Establishment of a Domestic Partnership.

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

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

1. 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.

2. Termination of employer contributions towards your or your Dependent's other coverage.

3. Exhaustion of COBRA continuation coverage or state continuation coverage.

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

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

1. Loss of eligibility for you or your Dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or

2. You or your Dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

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

LATE APPLICANTS

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

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

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

Should you wish to change from Family to Individual Coverage, contact your Group Administrator.

TERMINATION OF COVERAGE

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

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

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

2. When Blue Cross and Blue Shield does not receive the full amount of the premium payment or other charge, or amount on time, or when there is a bank draft failure of premiums for your and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or Dependents' coverage and the grace period, if any, has been exhausted.

3. You no longer live, reside or work in Blue Cross and Blue Shield's service area and/or live or reside in the Network Service Area.

4. Your coverage has been rescinded.

5. If you no longer meet the previously stated description of an Eligible Person.

6. If the entire coverage of your Group terminates.

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

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

Unless specifically mentioned elsewhere in this Certificate, if one of your Dependents becomes ineligible, his/her coverage will end as of the date the event occurs which makes him/her ineligible (for example, date of divorce).

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

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

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

Termination of a Dependent's Coverage: If one your Dependents no longer meets the description of an eligible family member as provided above under the heading "Family Coverage," his/her coverage will end as of the date the event occurs making 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 this Certificate.

CONTINUITY OF CARE

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

1. An Ongoing Course of Treatment for a serious acute disease or condition requiring complex ongoing care that you are currently receiving (for example, you are currently receiving Chemotherapy, radiation therapy, or post-operative visits for the serious acute disease or condition;

2. An Ongoing Course of Treatment for a Life-Threatening Disease or Condition and the likelihood of death is probable unless the course of the disease or the condition is interrupted;

3. An Ongoing Course of Treatment for the second and third trimester of pregnancy through the postpartum period; or

4. An Ongoing Course of Treatment for a health condition of which, a treating Provider attests that discontinuing the care by the In-Network Provider who is terminated from the network, would worsen the conditions or interfere with anticipated outcomes.

Continuity coverage described under this provision shall continue until the treatment is complete but will not extend for more than 90 days from the date of the notice to the covered person of the Provider's disaffiliation from network, or if the covered person has entered the second or third trimester of the pregnancy at the time of the Provider's disaffiliation, a period that includes the provision of postpartum care directly related to the delivery. If you are a new covered person whose Provider is not Participating, but is within the Network Service Area, you are able to continue receiving Covered Services with that Provider at the In-Network Provider benefit level to continue an Ongoing Course of Treatment as stated above, during a transition.

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

EXTENSION OF BENEFITS IN CASE OF TERMINATION

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

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

This extension of benefits will not apply to the following benefit section(s) under this Certificate: *Outpatient Prescription Drug Program benefit* section.

CONTINUATION OF COVERAGE AFTER TERMINATION
(Illinois State Laws)

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, under Illinois law. The provisions which apply to you will depend upon your status at the time of termination. The provisions described under Article A will apply if you are the Eligible Person (see definition) at the time of termination. The provisions described under Article B will apply if you are the spouse of a retired Eligible Person, or the party to a Civil Union with a retired Eligible Person and at least 55 years of age, or the former spouse of an Eligible Person, or a 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 under Article A 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 A.

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

ARTICLE A: Continuation of coverage if you are the Eligible Person

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

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

2. Continuation of coverage will not be available to you if:

a. You are covered by Medicare, except if you have been covered under a group Medicare supplement policy; or

b. You have coverage under any other health care program which provides group Hospital, surgical or medical coverage and under which you were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility; or

c. You decide to become a member of Blue Cross and Blue Shield.

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

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

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

6. Continuation of coverage under this Certificate will end on the date you become eligible for Medicare, become a member of Blue Cross and Blue Shield 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), that provides group Hospital, surgical or medical coverage. However, your continuation of coverage under this Certificate will also end on the first to occur of the following:

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

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

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

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

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

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

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

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

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

c. Instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.

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

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

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

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

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

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

5. 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, the monthly premium shall be computed as follows:

a. An amount, if any, that would be charged if you were a current employee of the employer, plus;

b. An amount, if any, that the employer would contribute toward the premium if you were a current employee; or

c. An additional amount, not to exceed 20% of a. and b. above, for costs of administration.

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:

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

2. 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;

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

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

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

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:

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

2. 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;

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

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

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

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.

Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield as specified in the *Eligibility, Enrollment and Termination Information* section under this Certificate.

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 as described under this Certificate.

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

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

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

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

3. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to Blue Cross and Blue Shield of the death of the Eligible Person, or of the Dependent Child reaching the limiting age, as well as notice of the Dependent Child's address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt

requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:

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

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

c. Instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.

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

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

6. The monthly charge will be computed as follows:

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

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

Failure to pay the initial monthly charge within 30 days after receipt of notice from Blue Cross and Blue Shield as required under 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; or

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

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

9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield as specified in the *Eligibility, Enrollment and Termination Information* section under 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 as described under this Certificate.

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

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

Continuation of Coverage: If you are a party to a Civil Union, or the Dependent Child of a party to a Civil Union, and you lose coverage under this Certificate, you have the same options as the spouse or Dependent Child of an Eligible Person to continue your coverage. The options available to a spouse or to a Dependent Child are described in the *Continuation of Coverage After Termination (Illinois State Laws)* section and the *Continuation Coverage Rights Under COBRA* section, if applicable to your Group.

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

In addition to the events listed in the *Continuation of Coverage After Termination (Illinois State Laws)* section and the *Continuation Coverage Rights Under COBRA* section, if applicable, continuation of coverage is available to you and your Dependent Children in the event you lose coverage because your 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 a Civil Union in the *Definitions* section under this Certificate. You are entitled to continue coverage for the same period of time as a spouse or Child who loses coverage due to divorce.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This *Continuation Coverage Rights Under COBRA* section does not apply to your Dependent who is a party to a Civil Union and their Children, or to your Domestic Partner and their Children.

NOTE: Certain employers may not be affected by this *Continuation of Coverage Rights Under COBRA* section. Please 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 under this Certificate. 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 a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage, must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his/her gross misconduct;
4. Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

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

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

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

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

1. The end of employment or reduction of hours of employment;
2. Death of the employee;
3. In the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
4. The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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 Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

CONTINUATION OF COVERAGE
FOR DOMESTIC PARTNERS

The purpose of this *Continuation of Coverage For Domestic Partners* section is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this Certificate as the Domestic Partner of an Eligible Person, or as the Dependent Child of a Domestic Partner. Your continued coverage under this Certificate will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage: If you are the Domestic Partner, or the Dependent Child of a Domestic Partner and you lose coverage under this Certificate, you have the same options as the spouse or Dependent Child of an Eligible Person to continue your coverage. The options available to a spouse or a Dependent Child are described in the *Continuation of Coverage After Termination (Illinois State Laws)* section and the *Continuation Coverage Rights Under COBRA* section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. Please see your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the *Continuation of Coverage After Termination (Illinois State Laws)* section and the *Continuation Coverage Rights Under COBRA* section, if applicable, continuation of coverage is available to you and your Dependent Children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of Domestic Partnership under the *Definitions* section under 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.

CLAIM FILING AND APPEALS PROCEDURES

In order to obtain your benefits under this Certificate, it is necessary for a Claim to be filed with Blue Cross and Blue Shield. To file a Claim, usually all you will have to do is show your Blue Cross and Blue Shield Identification Card to your Hospital or Physician (or other Provider) when you receive services. They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

Once Blue Cross and Blue Shield receives your Claim(s), it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases, Blue Cross and Blue Shield will send the payment directly to you, or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears in Blue Cross and Blue Shield's records.

In certain situations, you will have to file your own Claim(s). This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim(s), follow these instructions:

1. Complete a Claim Form. These are available by one of the following:

   a. Accessing the Blue Cross and Blue Shield website at www.bcbsil.com. Claim forms can be accessed by selecting Form Finder under the Member Services tab;

   b. From your Group Administrator; or

   c. By calling customer service at the toll-free telephone number on the back of your Identification Card.

2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis (including appropriate codes), the date of service and a description of the service (including appropriate codes) and the Claim Charge.

3. Mail the completed Claim Form with attachments to:

Blue Cross Blue Shield of Illinois
PO Box 660603
Dallas, TX 75266-0603

In any case, Claims should be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing a Claim(s), ask your Group Administrator or call your local Blue Cross and Blue Shield office.

INTERNAL CLAIM DETERMINATIONS AND APPEALS PROCESS

Initial Claim Determinations: Blue Cross and Blue Shield will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event Blue Cross and Blue Shield does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However,

an interest payment will not be made if the amount is $1.00 or less. Blue Cross and Blue Shield will usually notify you, your valid assignee, or your authorized representative when all information required to process a Claim, in accordance with the terms of the benefit program, within 30 days of the Claim's receipt. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provision in the *General Provisions* section under this Certificate.)

If a Claim is Denied or Not Paid in Full: If a Claim for benefits is denied, you or your authorized representative shall be notified in writing of the following:

1. The reason(s) for determination;

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

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

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

5. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA, following a final denial on internal review/appeal. Specifically, this explanation will include:

a. An explanation that if your case qualifies for external review, an Independent Review Organization (IRO) will review your case (including any data you would like to add).

b. An explanation that you may ask for an external review with an Independent Review Organization (IRO) not associated with Blue Cross and Blue Shield, and if your appeal was denied based on any of the reasons below. You may also ask for an external review if Blue Cross and Blue Shield failed to give you a timely decision (see 5c (ii) below) and your Claim was denied for one of these reasons:

(i) A decision about the medical need for, or the experimental status of, a recommended treatment; or
(ii) Your health care coverage was rescinded. For additional information, see the definition of Rescission under the *Definitions* section under this Certificate.

To ask for an external review, complete the Request for External Review form that will be provided to you and available at insurance.illinois.gov/externalreview and submit it to the Department of Insurance at the address shown below for external reviews.

c. An explanation that you may ask for an expedited (urgent) external review if:

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

(ii) Blue Cross and Blue Shield failed to give you a decision within 72 hours of your request for an expedited appeal;

(iii) The request for treatment is experimental or investigational, and your health care Provider states in writing that the treatment would be less effective if you promptly started; or

(iv) The Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which the covered person received Emergency Services, but has not been discharged from a facility.

d. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield sends you a written decision for appeals that need medical review within 15 business days after Blue Cross and Blue Shield receives any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service, or within 60 calendar days if you have already received the service. Decisions on expedited appeals are considered timely if Blue Cross and Blue Shield notifies you, your authorized representative, or your treating Physician, via verbal notification or written decision within 72 hours of your request for an expedited appeal. If verbal notification is received, Blue Cross and Blue Shield will send you a written decision within 48 hours from the time of verbal notification.

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

7. 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);

8. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield;

9. 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;

10. 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;

11. An explanation of the scientific or clinical judgement relied upon in the determination as applied to a 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;

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

13. The following contact information for the Illinois Department of Insurance Consumer Assistance and Ombudsman:

a. For complaints and general inquiries:

Springfield Office
Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767
866-445-5364: toll free
866-323-5321: TDD
217-782-4515: phone
217-782-5020: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

Chicago Office
122 S. Michigan Avenue, 19th floor
Chicago, IL 60603
312-814-2420: phone
312-814-5416: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

b. For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, IL 62767
Phone Number: (877) 850-4740
Fax: (217) 557-8495
DOI.externalreview@illinois.gov
http://insurance.illinois.gov/ExternalReview/ExternalReviewMain.html

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.

Urgent Care Clinical Claim is any pre-service Claim that requires Prior Authorization, as described under this Certificate, as a prerequisite for receiving benefits for Medical Care or treatment with respect to the application of regular time periods for making health claim decisions that 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 could be adequately managed without care or treatment.

Pre-Service Claim is any non-urgent request for benefits or a determination with respect to the terms of the benefit plan condition and receipt of the benefit, on approval of the benefit, in advance of obtaining Medical Care.

Post-Service Claim is notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished,

the date of service, the diagnosis, the Claim Charge, and any other information with Blue Cross and Blue Shield may request in connection with services rendered to you.

Urgent Care Clinical Claims*

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

*You do not need to submit Urgent Care Clinical Claims in writing. You should call Blue Cross and Blue Shield at the toll-telephone free number listed on the back of your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.

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

Pre-Service Claims

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

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

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

Post-Service Claims

Type of Notice or Extension	Timing
If your Claim is incomplete, Blue Cross and Blue Shield must notify you within:	30 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to Blue Cross and Blue Shield within:	45 days after receiving notice
Blue Cross and Blue Shield must notify you of the Claim determination (whether adverse or not):	
If the initial Claim is complete, within:	30 days*
After receiving the completed Claim (if the initial Claim is incomplete), within:	45 days

*The period may be extended one time by Blue Cross and Blue Shield for up to 15 days, provided that (1) it is determined that such an extension is necessary due to matters beyond the control of Blue Cross and Blue Shield; and (2) Blue Cross and Blue Shield notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which Blue Cross and Blue Shield expects to render a decision.

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

INQUIRIES AND COMPLAINTS

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

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

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

1. Claims; and
2. Quality of care.

When your Complaint relates to the 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" provision below.

To pursue an Inquiry or Complaint, you may contact customer service at the toll-free telephone 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 response to your Inquiry or Complaint within 30 days of receipt. Sometimes the acknowledgement and the response will be combined. If Blue Cross and Blue Shield needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted. If an Inquiry or Complaint is not resolved to your satisfaction, you may appeal to Blue Cross and Blue Shield.

CLAIM APPEAL PROCEDURES

Claim Appeal Procedures — Definitions

Adverse Benefit Determination meansa denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit in response to a Claim, pre-service Claim or urgent care clinical Claim, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an Ongoing Course of Treatment had been approved by Blue Cross and Blue Shield and Blue Cross and Blue Shield reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination.

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

Adverse Determination means:

1. A determination by Blue Cross and Blue Shield or its designee utilization review organization that, based upon the information provided, a request for a benefit under Blue Cross and Blue Shield's health benefit plan upon application of any utilization review technique does not meet Blue Cross and Blue Shield's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit; or

2. A Rescission of coverage determination. For additional information, see the definition of Rescission in the *Definitions* section under this Certificate.

Expedited Clinical Appeals: If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An ***expedited clinical appeal*** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, as well as a continued hospitalization. Before authorization of benefits for an Ongoing Course of Treatment is terminated or reduced, Blue Cross and Blue Shield will provide you with notice and an opportunity to appeal. For the Ongoing Course of Treatment, coverage will continue during the appeal process.

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

How to Appeal an Adverse Benefit Determination: You have the right to seek and obtain a review of any determination of a Claim, any determination of a request for Prior Authorization, or any other determination made by Blue Cross and Blue Shield in accordance with the benefits and procedures detailed under 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. Under your health benefit plan, there is one level of internal appeal available to you. In some circumstances, a health care Provider may appeal on his/her own behalf. Your designation of a representative must be in writing, as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call Blue Cross and Blue Shield at the toll-free telephone number on the back of your Identification Card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

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

1. Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write Blue Cross and Blue Shield to request a Claim review. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the Adverse Benefit Determination.

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

3. To contact Blue Cross and Blue Shield to request a Claim review or appeal an Adverse Benefit Determination, please use the following contact information or call the toll-free telephone number shown on the back of your Identification Card:

Claim Review Section
Blue Cross Blue Shield of Illinois
PO Box 660603
Dallas, TX 75266-0603

1-888-235-2936: fax
1-918-551-2011: fax number for urgent requests
Send a secure email by using the message center log into Blue Access for Members (BAM) at www.bcbsil.com

During the course of your internal appeal(s), Blue Cross and Blue Shield will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by Blue Cross and Blue Shield in connection with the appealed Claim, as well as any new or additional rationale for a denial at the internal appeals stage.

Such new or additional evidence or rational will be provided to you or your authorized representative as soon as possible, and sufficiently in advance of the date a final decision on appeal is made, in order to give you a reasonable opportunity to respond. Blue Cross and Blue Shield may extend the time period described under this Certificate for its final decision on an appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or part on a medical judgement, the appeal will be conducted by individuals associated with Blue Cross and Blue Shield and/or external advisors, but who were not involved in making the initial denial of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits, the claimant must exhaust the appeal process, must raise all issues with respect to a Claim, must file an appeal or appeals, and must have received a final appealed decision from Blue Cross and Blue Shield (except in situations where you are not required to exhaust the appeals process).

Timing of Non-Urgent Appeal Determinations: Upon receipt of a non-urgent concurrent, pre-service or post-service appeal, Blue Cross and Blue Shield will notify the party filing the appeal within three business days of all the information needed to review the appeal.

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

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

Notice of Appeal Determination: Blue Cross and Blue Shield will notify the party filing the appeal, you, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal.

The written notice will include:

1. The reason(s) 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 a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

4. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA, following a final decision on internal appeal. Specifically, this explanation will include:

a. An explanation that if your case qualifies for external review, an Independent Review Organization (IRO) will review your case (including any data you would like to add):

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

(ii) A decision about the medical need for or the experimental status of a recommended treatment;

(iii) Your health care coverage was rescinded. For additional information, see the definition of Rescission in the *Definitions* section under this Certificate.

To ask for an external review, complete the Request for External Review form that will provided to you and available at insurance.illinois.gov/externalreview*,* and submit it to the Department of Insurance at the address shown below for external review.

b. An explanation that you may ask for an expedited (urgent) external review if:

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

(ii) Blue Cross and Blue Shield failed to give you a decision within 72 hours of your request for an expedited appeal;

(iii) The request for treatment is experimental or investigational and your health care Provider states in writing that the treatment would be much less effective if not promptly initiated; or

(iv) The Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

c. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield sends you a written decision for appeals that need medical review within 15 business days after Blue Cross and Blue Shield receives any needed information, but no later than 30 calendar days if you are appealing before getting a service, or within 60 calendar days if you have already received the service. Decisions on expedited appeals are considered timely if Blue Cross and Blue Shield notifies you, your authorized representative, or your treating Physician, via verbal notification or written decision within 72 hours of your request for an expedited appeal. If verbal notification is received, Blue Cross and Blue Shield will send you a written decision within 48 hours from the time of verbal notification.

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

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

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

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

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

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

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

12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;

13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by you, a statement that all internal appeals have been exhausted, and the member has four months from the date of the letter to file an external review;

14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal the adverse determination and file an external review regardless of the status of a provider appeal;

15. The number of levels of appeals available (no more than two levels for group and one level for individual) under the plan, and the level of appeal applicable to the adverse determination within the notice;

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

17. The following contact information for the Illinois Department of Insurance Consumer Assistance and Ombudsman:

a. For complaints and general inquiries:

Springfield Office
Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767
866-445-5364: toll free
866-323-5321: TDD
217-782-4515: phone
217-782-5020: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

Chicago Office
122 S. Michigan Avenue, 19th floor
Chicago, IL 60603
312-814-2420: phone
312-814-5416: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

b. For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, IL 62767
Phone Number: (877) 850-4740
Fax: (217) 557-8495
DOI.externalreview@illinois.gov
http://insurance.illinois.gov/ExternalReview/ExternalReviewMain.html

If Blue Cross and Blue Shield's decision is to continue to deny, or partially deny, your Claim, or you do not receive a timely decision, you may be able to request an independent external review of your Claim by an independent third party, who will review the denial and issue a final decision. Your independent external review rights are described in the "Independent External Review" provision below.

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

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

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

Springfield Office
Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767
866-445-5364: toll free
866-323-5321: TDD
217-782-4515: phone
217-782-5020: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

Chicago Office
122 S. Michigan Avenue, 19th floor
Chicago, IL 60603
312-814-2420: phone
312-814-5416: fax
DOI.complaints@illinois.gov
mc.insurance.illinois.gov

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

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

If You Need Assistance: If you have any questions about the Claims procedures or the review procedure, please write Blue Cross and Blue Shield at the address shown below or call Blue Cross and Blue Shield at the toll-free telephone number shown on the back of your Identification Card . Blue Cross and Blue Shield offices are open from 8:00 a.m. to 6:00 p.m., Monday through Friday.

Blue Cross Blue Shield of Illinois
PO Box 660603
Dallas, TX 75266-0603

If you need assistance with internal Claims and appeals, or the independent external review process that is 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 toll-free telephone 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).

EXTERNAL REVIEW BY INDEPENDENT REVIEW ORGANIZATIONS

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

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

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 ("IDOI") within four months of receiving an Adverse Determination or Final Adverse Determination. Your request should be submitted to the IDOI at the following address:

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, IL 62767
Phone Number (877) 850-4740
Fax (217) 557-8495
DOI.externalreview@illinois.gov
http://insurance.illinois.gov/ExternalReview/ExternalReviewMain.html

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

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

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

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

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

3. There is no available standard health care services or treatment covered by Blue Cross and Blue Shield that is more beneficial than the recommended or requested service or treatment.

In addition, a) your health care Provider has certified in writing that the health care service or treatment is likely to be more beneficial to you, in the opinion of your health care Provider, than any available standard health care services or treatments, or b) your health care Provider who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat your condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.

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

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

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

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

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

1. Your pertinent medical records;

2. Your health care Provider's recommendation;

3. Consulting reports from appropriate health care Providers, and other documents submitted to Blue Cross and Blue Shield, or its designee utilization review organization, you, your authorized representative or your treating provider;

4. The terms of coverage under the benefit programs;

5. 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;

6. Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield, or its designated utilization review organization; and

7. 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 the notice of assignment to conduct an external review, with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the IRO will select one or more clinical reviewers, as it determines is appropriate, to conduct the external review, which clinical reviews must meet the minimum qualifications set forth in the Illinois Health Carrier External Review Act, and neither you, your authorized representative, if applicable, nor Blue Cross and Blue Shield will choose or control the choice of the Physicians or health care professionals to be selected to conduct the external review.

Each clinical reviewer will provide a written opinion to the IRO, within 20 days after being selected by the IRO, to conduct the external review on whether the recommended or requested health care services or treatment should be covered.

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

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

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

The written notice will include:

1. A general description of the reason for the request for external review;

2. The date the IRO received the assignment from the IDOI;

3. The time period during which the external review was conducted;

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

5. The date of its decisions;

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

7. The rationale for its decision.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination, and not for additional services or supplies beyond the scope of the external review. The IRO is not bound by any Claim determination reached prior to the submission of information to the IRO. The IDOI, you and your authorized representative, if applicable, and Blue Cross and Blue Shield will receive written notice from the IRO. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance's Office of Consumer Health Insurance.

Standard External Review

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

Expedited External Review: If you have a medical condition where the timeframe for completion of:

1. An expedited internal review of an appeal involving an Adverse Determination;

2. A Final Adverse Determination; or

3. A standard external review as described above would seriously jeopardize your life, health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received Emergency Services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after receipt of notice of a Final Adverse Determination, or if Blue Cross and Blue Shield 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/Investigational, and your health care Provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

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

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

Notification: Upon receipt of a request for an expedited external review, the IDOI shall immediately send a copy of the request to Blue Cross and Blue Shield. Blue Cross and Blue Shield shall immediately notify the IDOI, you and your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI.

The IDOI may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the IDOI's decision shall be in accordance with the terms of the benefit program (unless such terms are inconsistent with applicable law) and shall be subject to all applicable laws.

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

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

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

If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the IDOI, Blue Cross and Blue Shield and, if applicable, your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of Experimental/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 IDOI, Blue Cross and Blue Shield, you and your authorized representative, if applicable.

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

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

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

Expedited External Review

Expedited External Review	**Timing**
You may file a request for an expedited external review after the date of receipt of a Final Adverse Determination notice:	Immediately
You may file a request for an expedited external review, if Blue Cross and Blue Shield fails to provide a decision on a request for an expedited internal appeal within:	48 hours
Blue Cross and Blue Shield must immediately notify the IDOI, you, or your authorized representative, whether the request is complete and eligible for an expedited external review, or is ineligible for review, and may be appealed to the IDOI. The IDOI may make a determination that the request is eligible for an expedited external review, notwithstanding Blue Cross and Blue Shield's determination.	
The IDOI shall assign an independent review organization (IRO):	Immediately
Blue Cross and Blue Shield shall provide all necessary documents and information to the IRO:	Immediately, but not more than 24 hours after assignment of an IRO
If Blue Cross and Blue Shield fails to provide the necessary documents and information within the required time mentioned above, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination.	

The IRO shall provide notice of its decision to uphold or reverse the Adverse Determination, or Final Adverse Determination, to Blue Cross and Blue Shield, the IDOI, you or your authorized representative:	As expeditiously as your medical condition or circumstances require, but no more than 72 hours after the receipt of request.

External Review of Experimental or Investigational Treatment

Experimental or Investigational Treatment External Review	**Timing**
You may file a request with the IDOI for an external review after receipt of an Adverse Determination, or a Final Adverse Determination within:	4 months after date of receipt
If your treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may make an oral request for an expedited external review, after which the IDOI shall immediately notify Blue Cross and Blue Shield, and the time frames otherwise applicable to Expedited External Review shall apply.	
After the receipt for an external review, the IDOI shall send a copy of the request to Blue Cross and Blue Shield within:	1 business day
Blue Cross and Blue Shield shall complete a preliminary review of the request within:	5 business days
After completion of the preliminary review, Blue Cross and Blue Shield shall notify you, or your authorized representative, and the IDOI whether the request is complete and eligible for external review within:	1 business day
When the IDOI receives notice that the request is eligible for external review, they shall:	
Assign an IRO, and notify Blue Cross and Blue Shield of the name of the IRO, within:	1 business day
Notify you, or your authorized representative, of the request's eligibility and acceptance for external review, and the name of the IRO, within:	1 business day
If you are notified that your request for an external review has been accepted, you or your authorized representative, may submit additional information to the assigned IRO within:	5 business days
The assigned IRO shall then select one or more clinical reviewers within:	1 business day
Blue Cross and Blue Shield shall provide to the assigned IRO the documents and any information used in making the Adverse Determination or Final Adverse Determination within:	5 business days of notice of assigned IRO
After being selected by the assigned IRO, each clinical reviewer shall provide an opinion to the assigned IRO on whether the recommended or requested health care service shall be covered within:	20 days

Or, in the case of an expedited external review:	Immediately, but in no event more than 5 calendar days
The assigned IRO shall make a decision after receipt of the opinion from each clinical reviewer and provide notification of the decision to the IDOI, you, or your authorized representative, and Blue Cross and Blue Shield within:	20 days
Or, in the case of an expedited external review, within:	48 hours after receipt of the opinion of each clinical reviewer

GENERAL PROVISIONS

BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers ("Plan Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies, and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under certain circumstances described in its contracts with Plan Providers, Blue Cross and Blue Shield may:

1. Receive substantial payments from Plan Providers, with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Plan Provider;

2. Pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise; or

3. Receive from Plan Providers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums, or any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Certificate, and the calculation of all required Deductible and Coinsurance amounts payable by you under this Certificate, shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Group has been advised that Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Group, nor you, are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Providers work, please consider the following example:

1. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

2. You personally will have to pay the Deductible and Coinsurance amounts set out in your Certificate.

3. However, for purposes of calculating your Deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700, for purposes of calculating your Deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

4. Assuming you have already satisfied your Deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

5. After taking into account the deductible and Coinsurance amounts, Blue Cross and Blue Shield will satisfy its portion of the Hospital bill. In most cases, Blue Cross and Blue Shield has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money Blue Cross and Blue Shield would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then Blue Cross and Blue Shield has to satisfy the rest of the Hospital bill, or $860. Assuming Blue Cross and Blue Shield has a contract with the Hospital, Blue Cross and Blue Shield will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the $860 bill and whatever Blue Cross and Blue Shield ultimately pays under its contracts with Plan Providers, and neither you, nor your Group, are entitled to any part of these savings.

INTER-PLAN ARRANGEMENTS

Out-of-Area Services

Overview

Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, herein called "the Plan" has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside of the Plan's service area, the Claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program, and may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside the Plan's service area, you will receive it from two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. The Plan explains how we pay both types of Providers below.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits, except when paid as medical Claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the Plan to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, the Plan will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with, and generally handling, all interactions with its Participating Providers.

For Inpatient facility services received in a Hospital, the Host Blue's Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction.

When you receive Covered Services outside the Plan's service area, and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

1. The billed covered charges for your Covered Services; or
2. The negotiated price that the Host Blue makes available to the Plan.

To help you understand how this calculation would work, please consider the following example:

1. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your Identification Card to the Provider to let him/her know that you are covered by the Plan.

2. The Provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

3. The Host Blue, in turn, forwards the Claim to the Plan, and indicates that the negotiated price for the Covered Service is $80. The Plan would then base the amount you must pay for the service — the amount applied to your Deductible, if any, and your Coinsurance percentage — on the $80 negotiated price, not the $100 billed charge.

4. So, for example, if your Coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a Covered Service.

PLEASE NOTE: The Coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your Deductible and that there are no Copayments associated with the service rendered. Your Deductible(s), Coinsurance and Copayment(s) are specified in this Certificate.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider, or Provider group, that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price based on a discount that results in expected average savings for similar types of healthcare Providers, after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, also take into account adjustments to correct for over or underestimation of past pricing of Claims, as noted above. However, such adjustments will not affect the price we use for your Claim, because they will not be applied after a Claim has already been paid.

Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, the Plan may process your Claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement, will be calculated based on the lower of either Billed Charges for Covered Services or negotiated price (refer to the description of negotiated price under BlueCard Program) made available to the Plan by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare Provider bills above the specific reference benefit limit for the given procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a Nonparticipating Provider, that amount will be the difference between the Provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a Provider's billed charge, you will incur no liability, other than any related patient cost sharing under this agreement.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider incentives, risk-sharing and/or Care Coordinator Fees, that are a part of such an arrangement, except when a Host Blue passes these fees to the Plan through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If the Plan has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your employer on your behalf, the Plan will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees, as noted above, for the BlueCard Program

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws, or regulations, may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Plan will include any such surcharge, tax or other fee as part of the Claim Charge passed on to you.

Non-Participating Providers Outside the Plan's Service Area

Member Liability Calculation

In General: When Covered Services are provided outside of the Plan's service area by Non-Participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Certificate for Non-Participating Providers located inside our service area. You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make, for the Covered Services, as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network Emergency Services.

Exceptions: In some exception cases, the Plan may, but is not required to, negotiate a payment with such Non-Participating Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the Certificate for Non-Participating Providers located inside our service area (and described in "**In General**" above); or

2. The following:

a. For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or

b. For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the service center at 1-800-810-Blue (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

Inpatient Services: In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost share amounts/Deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. **You must contact the Plan to obtain Prior Authorization for non-emergency Inpatient services.**

Outpatient Services: Outpatient Services are available for Emergency Care, Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core International Claim form and send the Claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from the Plan, the service center or online at www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Servicing Plans:

In some instances, Blue Cross and Blue Shield has entered into agreements with other Blue Cross and Blue Shield Plans ("Servicing Plans") to provide, on Blue Cross and Blue Shield's behalf, Claim Payments and certain administrative services for you. Under these agreements, Blue Cross and Blue Shield will reimburse each Servicing Plan for all Claim Payments made on Blue Cross and Blue Shield's behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers ("Servicing Plan Providers") in their service area. The Servicing Plan will process your Claim in accordance with the Servicing Plan's applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by Blue Cross and Blue Shield for Claim Payments made by the Servicing Plan, applicable service charges, all benefit maximum amounts, and any required Deductible and Coinsurance amounts under this Certificate, will be calculated on the basis of the Servicing Plan Provider's Eligible Charge for Covered Services rendered to you, or the cost agreed upon between the Servicing Plan and Blue Cross and Blue Shield for Covered Services that the Servicing Plan passes to Blue Cross and Blue Shield, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount, or an average discount received or expected by the Servicing Plan, based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state's statutory method.

BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers: Blue Cross and Blue Shield hereby informs you, that it has arrangements with prescription drug providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under its arrangements with Participating Prescription Drug Providers, Blue Cross and Blue Shield may receive from these Providers, discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of prescription drugs will vary. Some discounts are currently based on Average Wholesale Price ("AWP") which is determined by a third party and is subject to change.

You understand that Blue Cross and Blue Shield may receive such discounts. Neither the Group, nor you, are entitled to receive any portion of any discounts. The drug fees/discounts that Blue Cross and Blue Shield has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate your share of the cost of prescription drugs for both retail and home delivery/specialty drugs. Except for home delivery/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to the Plan (and ultimately to you as described above).

Coinsurance amounts payable by you under this Certificate, will be calculated on the basis of the Provider's Eligible Charge, or the agreed upon cost, between the Participating Prescription Drug Provider and Blue Cross and Blue Shield for a prescription drug, whichever is lower. To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

1. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is $100. How is the $100 bill paid?
2. You personally will have to pay the Coinsurance amount set out in this Certificate.
3. However, for purposes of calculating your Coinsurance amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 prescription drug bill would be reduced by 20% to $80, for purposes of calculating your Coinsurance amount.
4. In our example, if your Coinsurance obligation is 25%, you personally will have to pay 25% of $80, or $20. You should note that your 25% Coinsurance is based upon the discounted amount of the prescription and not the full $100 bill.

For the home delivery Pharmacy and specialty Pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the home delivery Pharmacy and/or specialty Pharmacy program. Blue Cross and Blue Shield pays a fee to Prime for Pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and home delivery processing.

"Weighted Paid Claim" refers to the methodology of counting Claims for purposes of determining Blue Cross and Blue Shield's fee payment to Prime. Each retail (including Claims dispensed through PBM's specialty Pharmacy program) paid Claim is weighed in 34-day supply increments, so a 1-34 days' supply is considered one weighted Claim, a 35-68 days' supply is considered two weighted Claims and the pattern continues up to 6 weighted Claims for 171, or more days' supply. Blue Cross and Blue Shield pays Prime a Program Management Fee ("PMF") on a per weighted Claim days' supply.

The amounts received by Prime from Blue Cross and Blue Shield, pharmacies, manufacturers or other third-parties, may be revised from time to time. Some of the amounts received by Prime may be charged each time a Claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Blue Cross and Blue Shield (as described above), administrative fees charge by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Certificate. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be five and a half percent, (5.5%) of the total sales for all rebatable products of such a manufacturer, dispensed during any given calendar year to members of Blue Cross and Blue Shield and other Blue Plan operating divisions.

Blue Cross and Blue Shield's Separate Financial Arrangements with Pharmacy Benefit Managers: Blue Cross and Blue Shield owns a significant portion of the equity of Prime Therapeutics LLC and informs you that Blue Cross and Blue Shield has entered into one or more agreements with Prime Therapeutics LLC, or other entities (collectively referred to as "Pharmacy Benefit Managers"), to provide on Blue Cross and Blue Shield's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with Blue Cross and Blue Shield. In addition, the mail-order Pharmacy and specialty Pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC. Neither the Group, nor you, are entitled to receive any portion of any such rebates in excess of any amount that may be reflected in the premium.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of Blue Cross and Blue Shield, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). Blue Cross and Blue Shield may receive such rebates from Prime.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

Under this Certificate, Blue Cross and Blue Shield has the right to make any benefit payment either to you, or directly to the Provider of the Covered Services, unless reasonable evidence of a properly executed and enforceable assignment of benefit payment has been received by Blue Cross and Blue Shield. For example, Blue Cross and Blue Shield may pay benefits to you if you receive Covered Services from a Non-Plan Provider. Blue Cross and Blue Shield is specifically authorized by you to determine, to whom, any benefit payment should be made.

Once Covered Services are rendered by a Provider, you have no right to request Blue Cross and Blue Shield not pay the Claim submitted by such Provider, and no such request will be given effect. In addition, Blue Cross and Blue Shield will have no liability to you, or any other person, because of its rejection of such a request.

Except for the assignment of benefit payment described above, neither this Certificate, nor a covered person's Claim for benefits under this Certificate, is expressly non-assignable and non-transferable in whole, or in part, to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a covered person. Coverage under this Certificate is expressly non-assignable and non-transferable, and will be forfeited if you attempt to assign or transfer coverage, aid, or attempt to aid, any other person in fraudulently obtaining coverage. Any such assignment or transfer of a Claim for benefits or coverage shall be null and void.

YOUR PROVIDER RELATIONSHIPS

The choice of a Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.

Blue Cross and Blue Shield does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. Blue Cross and Blue Shield is not in any event liable for any act or omission of any Provider, or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by Blue Cross and Blue Shield. Any contractual relationship between a Physician and a Plan Hospital or other Plan Provider shall not be construed to mean that Blue Cross and Blue Shield is providing professional service.

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

Each Provider provides Covered Services only to you and does not deal with or provide any services to your Group (other than as an individual covered person), or your Group's ERISA Health Benefit Program.

AGENCY RELATIONSHIPS

The Group is your agent under this Certificate. The Group is not the agent of Blue Cross and Blue Shield.

All information you and your Group provide to Blue Cross and Blue Shield, will be relied upon as accurate and complete. Your Group must promptly notify Blue Cross and Blue Shield of any changes to such information.

NOTICES

Any information or notice that you furnish to Blue Cross and Blue Shield under this Certificate, must be in writing and sent to Blue Cross and Blue Shield at its offices located at 300 East Randolph, Chicago, Illinois 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice that Blue Cross and Blue Shield furnishes to you, must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield's records, or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative, as it appears in Blue Cross and Blue Shield's records. Blue Cross and Blue Shield may also provide such notices electronically to the extent permitted by law.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate, prior to the expiration of sixty (60) days after a Claim has been furnished to Blue Cross and Blue Shield, in accordance with the requirements under this Certificate. In addition, no such action shall be brought after the expiration of 3 years after the time a Claim is required to be furnished to Blue Cross and Blue Shield, in accordance with the requirements under this Certificate.

TIME LIMIT ON CERTAIN DEFENSES

After 2 years from the date of issue of this Certificate, no misstatements, except fraudulent misstatements, made by the applicant in the application for this Certificate, shall be used to void this Certificate or to deny a claim for illness or injury beginning after the expiration of such 2-year period.

INFORMATION AND RECORDS

You agree that it is your responsibility to ensure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, or 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 that might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury, or on account of any previous illness or injury, that may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield, or its agent, and agree that any such Provider, person or other entity may furnish to Blue Cross and Blue Shield, or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish Blue Cross and Blue Shield and/or your employer or Group Administrator, information regarding your, or your Dependents, becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status, in order that Blue Cross and Blue Shield be able to make Claim Payments in accordance with MSP laws.

PHYSICAL EXAMINATION AND AUTOPSY

Blue Cross and Blue Shield, at its own expense, shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder, and to make an autopsy in case of death where it is not forbidden by law.

VALUE BASED DESIGN PROGRAMS

Blue Cross and Blue Shield and your employer has the right to offer medical management programs, quality improvement programs and health behavior wellness incentive, maintenance, or improvement programs that allows for a reward, a contribution, a penalty, a differential in premiums, or medical, prescription drug or equipment Copayments, Coinsurance or Deductibles, or costs, or a combination of these incentives or disincentives, for participation in any such program offered or administered by Blue Cross and Blue Shield, or an entity chosen by Blue Cross and Blue Shield, to administer such programs. In addition, discount incentive programs for various health and wellness-related or insurance-related or other items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Blue Cross and Blue Shield makes available, at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by Blue Cross and Blue Shield's designated outside vendor and acceptance or declination of these services is optional to you. If you wish to accept such identity theft protection services, you will need to individually enroll in the program online at *www.bcbsil.com* or telephonically by calling the toll-free telephone number on your Identification Card. Services may automatically end if you no longer meet the definition of an Eligible Person. Services may change or be discontinued at any time with or without notice, and Blue Cross and Blue Shield does not guarantee that a particular vendor or service will be available at any given time. These services are provided as a convenience and are not considered covered benefits under this Certificate.

Contact your employer for additional information regarding any value-based programs offered by your employer.

CONFORMITY WITH STATE STATUTES

This Certificate provides, at a minimum, coverage as required under Illinois law. Laws in some other states require that certain benefits or provisions be provided to you if you are a resident of their state when the policy that insures you is not issued in your state. In the event any provision under this Certificate, on its effective date, conflicts with the laws of the state

in which you permanently reside, you will be provided the greater of the benefit under this Certificate, or that required under the laws of the state in which you permanently reside.

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 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 where you reside. To do this we may (a) communicate directly with you and/or (b) 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 this Certificate your Group has with Blue Cross and Blue Shield, to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

ENTIRE CONTRACT

The entire contract consists of a Group Policy, including the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, along with any exhibits, appendices, addenda and/or other required information, and the individual application(s) of the persons covered under the Policy, benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Group Policy, to extend the time for payment of premiums, or to waive any of the rights or requirements of Blue Cross and Blue Shield. No modifications of the Group Policy will be valid unless evidenced by an endorsement or amendment of the Group Policy, signed by an officer of Blue Cross and Blue Shield, and delivered to the Group.

OVERPAYMENT

If your Group's benefit plan or Blue Cross and Blue Shield pays benefits for eligible expenses incurred by you, or your Dependents, and it is found that the payment was more than it should have been, or it was made in error (“Overpayment”), your Group's plan or Blue Cross and Blue Shield has the right to obtain a refund of the Overpayment amount from:

1. The person to, or for whom, such benefits were paid; or

2. Any insurance company or plan; or

3. Any other persons, entities, or organizations, including, but not limited to, In-Network Providers or Out-of-Network Providers.

If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

1. Any future benefit payment made to any person or entity under this Certificate, whether for the same or a different member; or

2. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program; or

3. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or

4. Any future benefit payment, or other payment, made to any person or entity; or

5. Any future payment owed to one or more In-Network or Out-of-Network Providers.

Further, Blue Cross and Blue Shield has the right to reduce your benefit plan's, or policy's payment, to a Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy's Overpayment to the same Provider, and to remit the recovered amount to the other Blue Cross and Blue Shield's plan or policy.

FEDERAL BALANCE BILLING AND OTHER PROTECTIONS

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Illinois law, if there is a conflict between the terms of this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section and the terms in the rest of this Certificate, the terms of this section will apply. However, definitions set forth in the **FEDERAL NO SURPRISES ACT DEFINITIONS** provision of this section are for purposes of this section only.

CONTINUITY OF CARE

If you are under the care of a Participating Provider as defined in this Certificate who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

a. You are undergoing a course of treatment for a serious and complex condition;

b. You are undergoing institutional or Inpatient care;

c. You are scheduled to undergo nonelective Surgery from the Provider (including receipt of postoperative care from such Provider with respect to such Surgery);

d. You are pregnant or undergoing a course of treatment for your pregnancy; or

e. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving Chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized Medical Care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies you of the Provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the Child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the **CLAIM APPEAL PROCEDURES** provision in the **HOW TO FILE A CLAIM FILING AND APPEALS PROCEDURES** section of this Certificate.

FEDERAL NO SURPRISES ACT DEFINITIONS

The definitions below apply only to this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section. To the extent the same terms are also defined in the **DEFINITIONS SECTION** of this Certificate, those terms will apply only to their use in the Certificate or this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section, respectively.

"**Air Ambulance Services**" means, for purposes of this section only, medical transport by helicopter or airplane for patients.

"**Emergency Medical Condition**" means, for purposes of this section only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (a) placing the health of the individual, or with respect to a pregnant woman her unborn Child in serious jeopardy; (b) constituting a serious impairment to bodily functions; or (c) constituting a serious dysfunction of any bodily organ or part.

"**Emergency Services**" means, for purposes of this section only:

1. A medical screening examination performed in the emergency department of a Hospital or a Freestanding Emergency Department;

2. Further medical examination or treatment you receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until your condition is stabilized; and

3. Covered Services you receive from a Non-Participating Provider during the same visit after your Emergency Medical Condition has stabilized unless:

    a. Your Non-Participating Provider determines you can travel by non-medical or non-emergency transport

    b. Your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and

    c. You have provided informed consent.

"**Non-Participating Provider**" means, for purposes of this section only, with respect to a covered item or service, a Physician or other health care provider who does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan.

"**Non-Participating Emergency Facility**" means, for purposes of this section only, with respect to a covered item or service, an emergency department of a Hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan.

"**Participating Provider**" means, for purposes of this section only, with respect to a Covered Service, a Physician or other health care provider who has a contractual relationship with BCBSIL setting a rate (above which the Provider cannot bill the member) for furnishing such item or service under the Plan, regardless of whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the Plan.

"**Participating Facility**" means, for purposes of this section only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan, regardless of whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the Plan.

"**Qualifying Payment Amount**" means, for purposes of this section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"**Recognized Amount**" means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or Billed Charges.

FEDERAL NO SURPRISES ACT SURPRISE BILLING PROTECTIONS

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

a. Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.

b. Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections).

c. Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider. Additionally, under Illinois law, in the event there is a payment dispute between the Non-Participating Provider and BCBSIL, and attempts to negotiate a payment resolution are unsuccessful, the Non-Participating Provider or BCBSIL may initiate binding arbitration by filing a request with the Department of Insurance. The requesting party shall notify the non-requesting party that arbitration has been initiated, along with its final offer for settlement. The non-requesting party must also share its final offer with the requesting party before arbitration occurs. In the event there is still no resolution regarding the payment of services, the parties may move forward in the arbitration process with an impartial third-party arbiter pursuant to the provisions in 215 ILCS 5/356z.3a.

Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or Billed Charges.

For Included Services, these cost-share requirements will be counted toward your Participating Provider Deductible and/or Out-of-Pocket Limit, if any.

FEDERAL NO SURPRISES ACT PROHIBITION OF BALANCE BILLING

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill you is your in-network cost-share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

DEFINITIONS

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

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

Acute Treatment Services means a 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment individual and group counseling, psychoeducational groups, and discharge planning.

Advanced Practice Nurse means a Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist operating within the scope of such license.

Ambulance Transportation means local transportation in specially equipped certified ground and air transportation options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided primarily for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this Certificate.

Ambulance Transportation Eligible Charge means:

1. For ambulance providers that bill for Ambulance Transportation services through a Participating Hospital, the Ambulance Transportation Eligible Charge will utilize the applicable Average Discount Percentage (“ADP); and

2. For all other ambulance providers, the Ambulance Transportation Eligible Charge is such provider’s Billed Charge.

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 Covered Services when operating within the scope of such license.

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

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

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

Approved Clinical Trial means phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is one of the following:

1. A federally funded or approved trial;

2. A clinical trial conducted under an FDA Experimental/Investigational new drug application; or

3. A drug that is exempt from the requirement of an FDA Experimental/Investigational new drug application.

Audiologist means a duly licensed Audiologist operating within the scope of his or her license.

In-Network Audiologist means an Audiologist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time Covered Services are rendered.

Out-of-Network Audiologist means an Audiologist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to you at the time Covered Services are rendered.

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

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

Behavioral Health Practitioner means a Physician or Professional Provider who is duly licensed to render services for Mental Illness or Substance Use Disorders and is operating within the scope of such license.

Behavioral Health Unit means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Treatment benefits. It Includes:

1. Prior Authorization;

2. Emergency Mental Illness or Substance Use Disorder admission and length of stay/service review for Inpatient Hospital admission; and/or

3. Review of Outpatient services for the treatment of Mental Illness and Substance Use Disorder.

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

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

BlueChoice means a network of selected Providers established by Blue Cross and Blue Shield.

Care Coordination means organized, information-driven patient care activities intended to facilitate the appropriate responses to covered person's healthcare needs cross the continuum of care.

Care Coordinator Fee means a fixed amount paid by a Blue Cross and/or Blue Shield Plan to Providers periodically for Care Coordination under a Value-Based Program.

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

Certified Clinical Nurse Specialist means a nurse specialist who: (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and Hospital referral; and (c) meets the following qualifications:

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

2. Is a graduate of an advanced practice nursing program.

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

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

2. Is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

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

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

2. Is a graduate of an advanced practice nursing program.

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

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

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

Chiropractor means a duly licensed chiropractor operating within the scope of such license.

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

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

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

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

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

Clinical Professional Counselor means a duly licensed clinical professional counselor operating within the scope of such license.

Clinical Social Worker means a duly licensed clinical social worker operating within the scope of such license.

Clinical Stabilization Services means a 24-hour treatment, usually following Acute Treatment Services for Substance Use Disorder. This which may include intensive education and counseling regarding the nature of addiction and the consequences, relapse prevention, outreach to families and significant others of the member, and aftercare planning for individuals beginning to engage in recovery from addiction.

Clinician means a person operating within the scope of his/her license, registration or certification in the clinical practice or medicine, psychiatry, psychology or behavior analysis.

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

Coinsurance means a percentage of an eligible expense that you are required to pay towards a Covered Service or for each Prescription filled or refilled through a Covered Pharmacy.

Complications of Pregnancy means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

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

Coordinated Home Care Program means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

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

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

Copayment means a specified dollar amount that you are required to pay towards a Covered Service.

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:

1. A group health plan.
2. 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.
3. Medicare (Parts A or B of Title XVIII of the Social Security Act).
4. Medicaid (Title XIX of the Social Security Act).
5. Medical Care for members and certain former members of the uniformed services and their Dependents.
6. A Medical Care program of the Indian Health Service or of a tribal organization.
7. A State health benefits risk pool.
8. A health plan offered under the Federal Employees Health Benefits Program.
9. 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.
10. A health benefit plan under Section 5(e) of the Peace Corps Act.
11. State Children's Health Insurance Program (Title XXI of the Social Security Act).

Custodial Care Service means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can

be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

Deductible means the dollar amount of Eligible Charges for Covered Services that you must pay before benefits are payable under the Policy. Deductible is described in the "Your Deductible" provision of the *How Your Benefit Plan Works* section. The amount of the Deductible and the frequency (annual or per occurrence) are shown in the *Summary of Benefits* section of this Certificate

Dentist means a duly licensed Dentist operating within the scope of such license.

Dependent means an Eligible Person's spouse, party to a Civil Union, Domestic Partner, or any Child(ren) covered under this Certificate.

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

Diagnostic Mammogram means a mammogram obtained using Diagnostic Mammography.

Diagnostic Mammography means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

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

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

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

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

Domestic Partner means a person with whom you have entered into a Domestic Partnership.

Domestic Partnership means long-term committed relationship of indefinite duration with a person which meets the following criteria:

1. You and your Domestic Partner have lived together for at least 6 months;

2. Neither you nor your Domestic Partner is married to anyone else or has another domestic partner;

3. Your Domestic Partner is at least 18 years of age and mentally competent to consent to contract;

4. Your Domestic Partner resides with you and intends to do so indefinitely;

5. You and your Domestic Partner have an exclusive mutual commitment similar to marriage; and

6. You and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

Durable Medical Equipment Provider means a duly licensed durable medical equipment provider when operating within the scope of such license.

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

Eligible Charge means:

1. in the case of a Provider, other than a Professional Provider, which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to you in the benefit program or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services; and

2. in the case of a Provider, other than a Professional Provider, which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to you in the benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, the following amount:

a. The lesser of (unless otherwise required by applicable law or arrangement with Out-of-Network Providers);

(i) The Provider's Billed Charges; and

(ii) An amount determined by Blue Cross and Blue Shield of Illinois to be approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

b. If there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection a. above based upon the information submitted on the Claim, the lesser of (unless otherwise required by applicable law or arrangement with Out-of-Network Providers):

(i) The Provider's Billed Charges; and

(ii) An amount determined by Blue Cross and Blue Shield of Illinois to be 150% of the Eligible Charge that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

c. If the base Medicare reimbursement amount and the Eligible Charge cannot be determined under subsections a. or b. above, based upon the information submitted on the Claim, then the amount will be 50% of the Provider's Billed Charges. However Blue Cross and Blue Shield may limit such amount to the lowest contracted rate that Blue Cross and Blue Shield has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to you.

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

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

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Eligible Charge for Out-of-Network or Non-Plan Providers will be 50% of the Out-of-Network or Non-Plan Provider's standard billed charge for such Covered Service. (See provisions of this Certificate regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

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

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

Any change to the Medicare reimbursement amount will be implemented by Blue Cross and Blue Shield of Illinois within 190 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Eligible Person means an employee of the Group who meets the eligibility requirements for this health coverage, as described in the *Eligibility, Enrollment and Termination Information* section of this Certificate.

Emergency Accident Care means the initial Outpatient treatment of accidental injuries including related Diagnostic Service.

Emergency Medical Care means services provided for the initial Outpatient treatment, including related Diagnostic Services, of an Emergency Medical Condition.

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

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy;

2. Serious impairment to bodily functions;

3. Serious dysfunction of any bodily organ or part;

4. Inadequately controlled pain; or

5. With respect to a pregnant woman who is having contractions:

a. Inadequate time to complete a safe transfer to another hospital before delivery; or

b. A transfer to another hospital may pose a threat to the health or safety of the woman or unborn Child.

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

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

Experimental/Investigational Services and Supplies means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment for the condition being treated or, if any of such items required federal or other governmental agency approval, such approval was not granted at the time Covered Services were provided. Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. As used herein, medical treatment includes medical, surgical, mental health treatment, Substance Use Disorder Treatment or dental treatment.

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States, and:

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

2. Alleviating the condition being treated;

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

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

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

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

Family Coverage means coverage for you and your eligible Dependents under this Certificate.

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

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

Habilitative Services means Occupational Therapy, Physical Therapy, Speech Therapy, and other health care services that help an Eligible Person keep, learn or improve skills and functioning for daily living, as prescribed by a Physician pursuant to a treatment plan. Examples include therapy for a Child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a Child to function with a Congenital, Genetic, or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for an eligible person with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this Certificate.

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.

Hearing Aid means any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold.

Hearing Care Professional means a person who is a licensed Hearing Aid dispenser, licensed Audiologist, or licensed Physician operating within the scope of such license.

Home Infusion Therapy Provider means a duly licensed home infusion therapy provider when operating within the scope of such license.

Hospice Care Program Provider means an organization duly licensed to provide Hospice Care Program Service when operating within the scope of such license.

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

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

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

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

Iatrogenic Infertility means an impairment of fertility by Surgery, radiation, Chemotherapy, or other medical treatment affecting reproductive organs or processes.

Identification Card means the card issued to the covered member by Blue Cross and Blue Shield of Illinois providing pertinent information applicable to his/her coverage.

Individual Coverage means coverage under this Certificate for yourself but not your spouse and/or Dependents.

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

1. The inability to conceive a Child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman 35 years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12 month or 6-month term for determining Infertility);

2. A person's inability to reproduce either as a single individual or with a partner without medical intervention; or

3. A licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Infusion Suite means a safe alternative to Hospitals and clinic based infusion setting where specialty medications can be infused.

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

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

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

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorders or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorders. Requirements: Blue Cross and Blue Shield requires that any Mental Illness and/or Substance Use Disorder Intensive Outpatient Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by Blue Cross Blue Shield as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Investigational or Investigational Services and Supplies means procedures, drugs, devices, services and/or supplies which:

1. 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

2. 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 you; and

3. Specifically with regard 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 you.

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

Life-Threatening Disease or Condition means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Long-Term Antibiotic Therapy means the administration of oral, intramuscular, or intravenous antibiotics singly or in combination for periods of time in excess of 4 weeks.

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

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

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Marriage And Family Therapist ("LMFT") means a duly licensed marriage and family therapist operating within the scope of such license.

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

Maximum Allowance means:

1. For Participating Professional Providers, the amount they have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by In-Network Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. Benefit payments for Covered Services rendered by BlueChoice network Professional Providers will be based upon the applicable BlueChoice payment tier appropriate for that Provider. However, benefit payments for Covered Services rendered by Professional Providers in the Participating Provider Option network, but not in the BlueChoice network will be based upon the Schedule of Maximum Allowances applicable to the Participating Provider Option network which these Providers have agreed to accept as payment in full. Benefit payment for Covered Services rendered by Participating Professional Providers for the treatment of Mental Illness and/or Substance Abuse Treatment will be based on the Schedule of Maximum Allowances applicable to Managed Care Mental Health and Substance Abuse Treatment benefits which these Providers have agreed to accept as payment in full.

2. For Out-of-Network Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with Out-of-Network Providers):

a. The Provider's Billed Charges; or

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

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

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

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined based on the information submitted on the Claim, the Maximum Allowance for Out-of-Network Professional Providers will be 100% of the Out-of-Network Professional Provider's standard billed charge for such Covered

Service. If there is no rate according to the Schedule of Maximum Allowance, then the Maximum Allowance will be 25% of Billed Charges.

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

Any change to the Medicare reimbursement amount will be implemented by Blue Cross and Blue Shield of Illinois within 190 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

May Directly or Indirectly Cause means the likely possibility that treatment will cause a side effect of Infertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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

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

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that Blue Cross and Blue Shield will pay the cost of the hospitalization, services or supplies. Please refer to the *Exclusions – What Is Not Covered* section of this Certificate for additional information.

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

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

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's initial decision, your benefit program provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield,

either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so as described in the *Claim Filing and Appeals Procedures* section of this Certificate.

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

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

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

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

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

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

Medicare means the program established by Title XVIII of the Social Security Act (42 U.S.C. w1395 et seq.).

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

Medicare Secondary Payer or MSP means those provisions of the Social Security Act set forth in 42 U.S.C. w1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, Dependent Children.

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

Naprapath means a duly licensed Naprapath operating within the scope of such license.

Naprapathy Services means the performance of Napropathy practice by a Naprapath which may legally be rendered by them.

Network Service Area means the geographic area designated by Blue Cross and Blue Shield of Illinois within which the Benefits of this Plan are available to a covered person. This Plan accepts a covered person if they reside live or work in the geographic Network Service Area. In addition, routine non-Emergency Services are generally limited to Providers within the service area, however, members may choose to receive services from Providers outside of the Network Service Area. A covered person may call the customer service toll-free telephone number on the back of your Identification Card or visit the Blue Cross and Blue Shield website at www.bcbsil.com to determine if he or she is in the Network Service Area.

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

Non-Plan Hospital – see definition of **Hospital**.

Non-Plan Provider – see definition of **Provider**.

Occupational Therapist means a duly licensed occupational therapist operating within the scope of such license.

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

Ongoing Course of Treatment has a meaning set forth in the provision entitled, “Continuity of Care.”

Optometrist means a duly licensed optometrist operating within the scope of such license.

Orthotic Provider means a duly licensed orthotic provider operating within the scope of such license.

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

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

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

Participating Provider Option means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

Pediatric Palliative Care means, for Children under the age of 21, care focused on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Pediatric Palliative Care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person-centered and family-centered approach to care, providing people living with serious illness relief from the symptoms and

stress of an illness. Through early integration into the care plan for the seriously ill, palliative care improves quality of life for the patient and the family. Palliative care can be offered in all care settings and at any stage in a serious illness through collaboration of many types of care providers.

Pharmacy means a state and federally licensed establishment:

1. That is physically separate and apart from any Provider's office; and
2. Where Legend Drugs and devices are dispensed under prescriptions to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he/she practices.

Physical Therapist means a duly licensed physical therapist operating within the scope of such license.

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

Physician means a physician duly licensed to practice medicine in all of its branches operating within the scope of such license.

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

Plan Hospital – see definition of **Hospital**.

Plan Provider – see definition of **Provider**.

Podiatrist means a duly licensed podiatrist operating within the scope of such license.

Post-Service Medical Necessity Review means a review, sometimes referred to as a retrospective review or post-service Claims request and is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

Prior Authorization means a requirement that you must obtain authorization from Blue Cross and Blue Shield before you receive certain types of Covered Services designated by Blue Cross and Blue Shield.

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

Professional Provider – see definition of **Provider**.

Prosthetic Provider means a duly licensed prosthetic provider operating within the scope of such license.

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

Plan Provider means a Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to you at the time Covered Services are rendered to you.

Non-Plan Provider means a Provider that does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

Participating Provider means a Plan Hospital, Plan facility or Professional Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in a BlueChoice program utilizing the BlueChoice network.

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

Participating Professional Provider means a Professional Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to participants in a Participating Provider Option program or a Professional Provider who has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Professional Provider.

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

Participating Prescription Drug Provider (or Participating Pharmacy) means a Preferred or Non-Preferred Pharmacy, including but not limited to, an independent retail Pharmacy, chain or retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy that has a written agreement with Blue Cross and Blue Shield, or with the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide Covered Services to you at the time rendered.

Non-Participating Prescription Drug Provider (or Non-Participating Pharmacy) means a Pharmacy, including but not limited to, an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or Specialty Drug Pharmacy which has not entered into a written agreement with Blue Cross and Blue Shield or an entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, for such Pharmacy to provide pharmaceutical services to you at the time services are rendered.

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

Psychologist means a Registered Clinical Psychologist operating within the scope of such license.

Qualified ABA Provider means a Provider operating within the scope of his/her license registration or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:

1. Master's level, independently licensed Clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided, for services treating Autism Spectrum Disorder (ASD) symptoms, with or without applied behavior analysis (ABA) service techniques; or

2. Master's level Clinician whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e. Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst Doctoral (BCBA-D), to supervise and provide treatment planning, with ABA services technique; or

3. Health Care Practitioner who is certified as a provider under the TRICARE military health system, if requesting to provide ABA service; or

4. Master's level Clinician with a specific professional credential or certification recognized by the state in which the clinician is located; or

    a. Developmental Therapist with Certified Early Intervention Specialist credential or CEIS; or

    b. If the Doctor or Medicine (MD) prescribes ABA and writes a MD order for services to the provided by a specific person.

For the para-professional/line therapist:

1. Two years of college educated staff person with a Board Certified Assistant Behavior Analyst (BCaBA) for the para-professional/therapist; or

2. A bachelor level or high school graduate having obtained a GED a staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist; or

3. A person who is "certified as a provider under TRICARE military health system", if requesting to provide ABA services.

    a. Developmental Therapist with Certified Early Intervention Specialist credential or CEIS; or

    b. If the Doctor or Medicine (MD) prescribes ABA and writes a MD order for services to the provided by a specific person.

Recommended Clinical Review means an optional voluntary review of Provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and Medical Necessity requirements.

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

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

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

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

Registered Dietician means a duly licensed Clinical Professional Counselor operating with the scope of his or her license.

Registered Surgical Assistant means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of such license.

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.

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

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

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

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

Routine Patient Costs means the cost for all items and services consistent with the coverage provided under this Certificate that is typically covered for you if you are not enrolled in a clinical trial.

Routine Patient Costs do not include:

1. The investigational item, device, or service, itself;

2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

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

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

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

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

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

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

Speech Therapist means a duly licensed speech therapist operating within the scope of such license.

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

Standard Fertility Preservation Services means procedure based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society for Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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

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

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

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

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

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

Telehealth and Telemedicine Services means a health service delivered using telecommunications and information technology by a health care professional licensed, certified or registered to practice in Illinois and acting within the scope of his/her license, certification or registration to a patient in a different physical location than the health care professional.

Temporomandibular Joint Dysfunction and Related Disorders means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

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

1. A severe infection with borrelia burgdorferi;

2. A late stage, persistent, or chronic infection or complications related to such an infection;

3. An infection with other strains of borrelia or a tick-borne disease that is recognized by the United States Centers for Disease Control and Prevention; and

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

Totally Disabled means:

1. 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

2. With respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

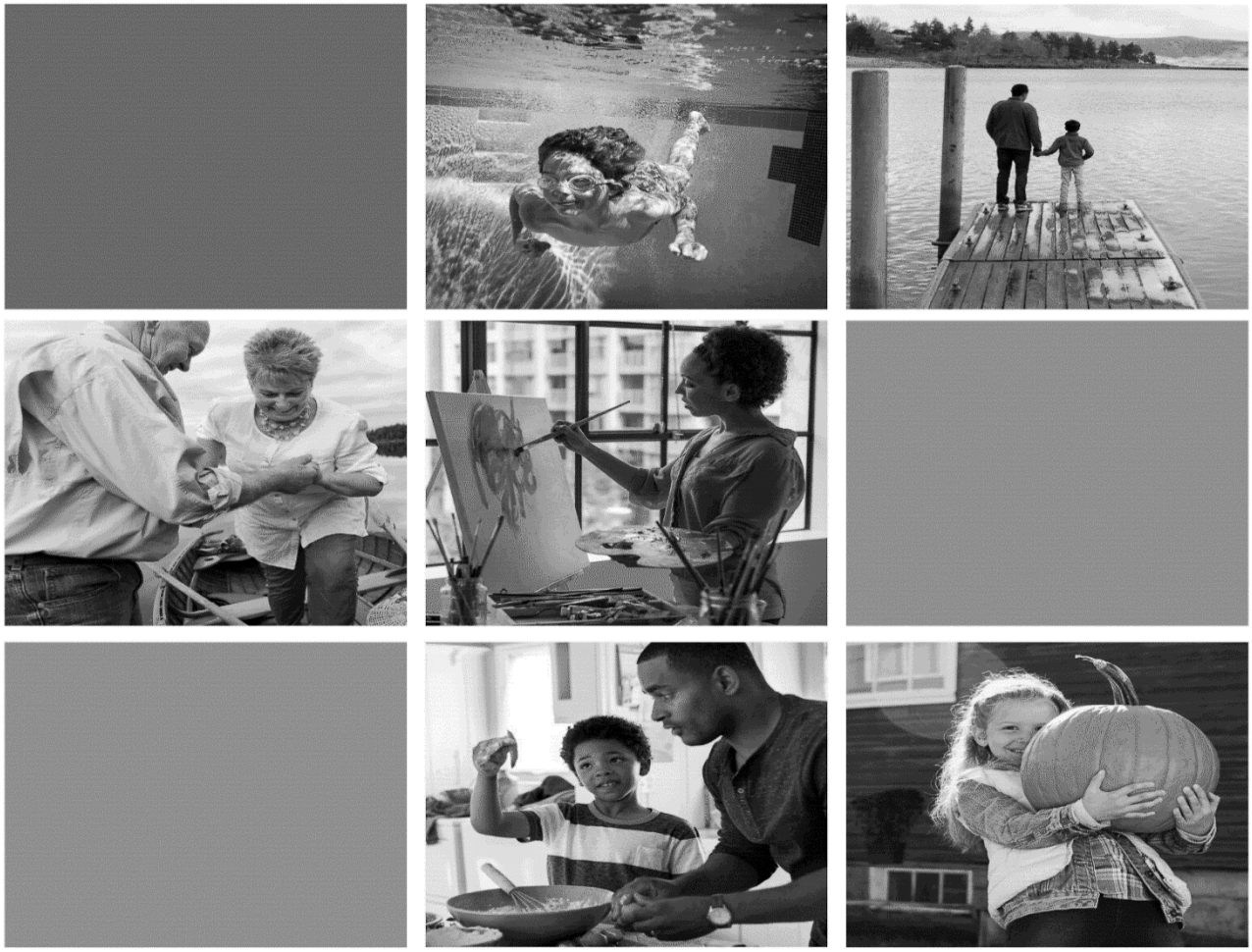
Transplant Lodging Eligible Expense means the amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

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

Virtual Provider means a licensed Provider who has a written agreement with Blue Cross and Blue Shield to provide diagnosis and treatment of injuries and illnesses through either a licensed Provider who has a written agreement with Blue Cross and Blue Shield to provide diagnosis and treatment of injuries and illnesses through either 1) interactive audio communication (via telephone or other similar technology) or 2) interactive audio/video examination and communication (via online portal, mobile application or similar technology) to you at the time services are rendered, operating within the scope of such license.

Virtual Visit means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the "Virtual Visits" provision under the *Physicians and Other Professional Services* section of this Certificate.

Vitamin D Testing means vitamin D blood testing that measures the level of vitamin D in a person's blood.



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