Your Health Care Policy

BLUE PRECISION HMO

a product of
Blue Cross and Blue Shield of Illinois

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

A message from

BLUE CROSS AND BLUE SHIELD

This Policy describes the Blue Precision HMO health care benefits that will be provided to you by 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. The Definitions Section will explain the meaning of many of the terms used in this Policy. All terms used in this Policy, when defined in the Definitions Section, begin with a capital letter. Whenever the term ‘‘you’’ or ‘‘your’’ is used, we also mean all eligible family members who are covered under Family Coverage.

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

We suggest that you read this entire Policy very carefully. We hope that any questions that you might have about your coverage will be answered here.

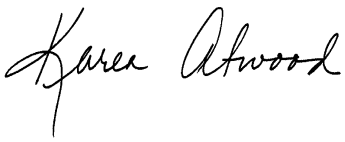
This Policy is currently certified as a Qualified Health Plan.

THIS POLICY REPLACES ANY PREVIOUS POLICIES THAT MAY HAVE BEEN ISSUED TO YOU BY BLUE CROSS AND BLUE SHIELD.

If you have any questions once you have read this Policy, please call your local Blue Cross and Blue Shield office. It is important to all of us that you understand the protection this coverage gives you.Should you have any questions regarding your eligibility under this Policy, please contact your local Blue Cross and Blue Shield office.

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

Sincerely,



BCBSIL Plan President

RIGHT TO EXAMINE THIS POLICY

You have the right to examine this Policy for a 10 day period after receiving it. If, for any reason, you are not satisfied with the health care benefit program described in this Policy, you may return the Policy and your identification card(s) to Blue Cross and Blue Shield and void your coverage. Any premium that you had paid to Blue Cross and Blue Shield will be refunded to you provided that you do not receive any services or have any Claims paid under this Policy before the end of the 10-day period.

GUARANTEED RENEWABILITY

Coverage under this Policy will be terminated for nonpayment of premiums. Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number, is not renewed or if Blue Cross and Blue Shield ceases to offer a particular type of coverage in the individual market. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior written notice.
   b. You may convert to any other individual policy offered to the individual market.
   c. If Blue Cross and Blue Shield should terminate or refuse to terminate this Policy, it must do so uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
2. If Blue Cross and Blue Shield discontinues all health care coverage and does not renew all health insurance Policies it issues or delivers for issuance in the individual market in the state. If this should occur, Blue Cross and Blue Shield will give you at least 180 days prior written notice.
3. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice.
4. You no longer reside, live or work in the Blue Cross and Blue Shield's network service area;.
5. Failure to pay your premium in accordance with the terms of the Policy.

Blue Cross and Blue Shield will not terminate or refuse to renew this Policy because of the condition of your health.

NOTICE OF ANNUAL MEETING

You are hereby notified that you are a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and you are entitled to vote in person, or by proxy, at all meetings of Members of Blue Cross and Blue Shield. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The term "Member" as used above refers only to the person to whom this Policy has been issued, the Enrollee. Under Family Coverage, the term "Member" does not include any person other than the Enrollee unless such person is acting upon the Enrollee's behalf.

YOUR SCHEDULE PAGE

A Schedule Page has been inserted into and is part of this Policy. The Schedule Page contains specific information about your coverage including, but not limited to:

- whether you have Individual Coverage or Family Coverage;
- the amount of your Deductible(s) ,and/or Copayment(s),and/or Coinsurance amount;and
- the Hospital and Physician benefit payment levels; and
- the premium amount and the method of payment.

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

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ELIGIBILITY AND PREMIUM INFORMATION

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

- Have applied for and been confirmed as eligible for this coverage as determined by Blue Cross and Blue Shield;
- Have received a Blue Cross and Blue Shield identification card; and
- Live within Blue Cross and Blue Shield's service area (Contact Customer Service at the number shown on your ID card for information regarding the service area); and.
- Reside, live or work in the geographic "network service area" designated by Blue Cross and Blue Shield. You may call Customer Service at the number shown on your ID card to determine if you are in the Network Service Area or log on to the Web site at *www.bcbsil.com*; and.
- If Medicare eligible, have both Part A and Part B coverage.

APPLYING FOR COVERAGE

You may apply for coverage for yourself and/or your eligible dependents (see below) by submitting the application(s) for individual medical insurance form along with any exhibits, appendices, addenda and/or other required information ("Application(s)") to Blue Cross and Blue Shield. The Application(s) for coverage may or may not be accepted. (Blue Cross and Blue Shield cannot use genetic information or require genetic testing in order to limit or deny coverage.)

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health status related factor. You will not be discriminated against for coverage under this Policy 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 Policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

You may enroll in or change coverage for yourself and/or you eligible dependents during one of the following enrollment periods. Your and/or your eligible family members effective date will be determined by Blue Cross and Blue Shield, depending upon the date your application is received, payment of the initial premiums no later than the day before the effective date of coverage 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 orders) that an individual qualifies as an eligible dependent under this Policy.

YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD

You will receive an identification (ID) card from Blue Cross and Blue Shield. Your ID card contains your identification number, the name of the Participating IPA/Participating Medical Group that you have selected and the phone number to call in an emergency. Always carry your ID card with you. The ID card is part of your coverage. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, go to Blue Access for Members (BAM) to order or replace cards or contact customer service at the number on the back of your ID card.

Annual Open Enrollment Period/Effective Date of Coverage

You may apply for or change coverage for yourself and/or your eligible dependents during the annual open enrollment period.

When you enroll during the annual open enrollment period, your and/or your eligible dependents effective date will be the following January 1, unless otherwise designated by Blue Cross and Blue Shield.

This section "Annual Open Enrollment Period/Effective Date of Coverage" is subject to change by Blue Cross and Blue Shield, and/or applicable law, as appropriate.

Limited Enrollment Periods/Effective Date of Coverage

Limited enrollment periods have been designated during which you may apply for or change coverage for yourself and/or your eligible dependents. You must apply for coverage within 60 days from the date of a limited enrollment event. Except as otherwise provided below, if you apply between the first day and the 15th day of the month, your effective date will be no later than the first day of the following month, or if you apply between the 16th day and the end of the month, your effective date will be no later than the first day of the second following month.

Limited Enrollment Events:

1. You and/or your eligible dependents experience a loss of Minimum Essential Coverage. New coverage for you and/or your eligible dependents will be effective no later than the 1st day of the month following the loss.

   A loss of Minimum Essential Coverage does not include failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage, or situations allowing for a Rescission, as determined by Blue Cross and Blue Shield.

   For purposes of this Limited Enrollment Periods/Effective Dates of Coverage section, "Minimum Essential Coverage" means health insurance coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, group or government health insurance coverage. For additional information on whether a particular coverage is recognized as "Minimum Essential Coverage", please call the customer service number on the back of your identification card or visit *www.cms.gov.*

2. You and/or your eligible dependents gain a dependent or become a dependent through marriage or establishment of a Domestic Partnership. New coverage for you and/or your eligible dependents will be effective no later than the first day of the following month.

3. You and/or your eligible dependents gain a dependent through birth, placement of a foster child, adoption, or placement for adoption or court-ordered dependent coverage. New coverage for you and/or your eligible dependents will be effective on the date of the birth, adoption, placement of the foster child, or placement for adoption. The effective date for court-ordered eligible Child(ren) coverage will be determined by Blue Cross and Blue Shield in accordance with the provisions of the court order.

4. You and/or your eligible dependents enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous as evaluated and determined by Blue Cross and Blue Shield, as appropriate.

5. You and/or your eligible dependents adequately demonstrate that the QHP in which you are enrolled substantially violated a material provision of its contract in relation to you.

6. You and/or your eligible dependents are determined newly eligible or newly ineligible for advance payments of the Premium Tax Credit or have a change in eligibility for cost-sharing reductions, regardless of whether you are already enrolled in a QHP.

   For purposes of this Limited Enrollment Periods/Effective Dates of Coverage section, "Premium Tax Credit" means a refundable Premium Tax Credit you may receive for taxable years ending after December 31, 2013, to the extent provided for under applicable law, where the credit is meant to offset all or a portion of the premium paid by you for coverage obtained during the preceding calendar year.

7. You and/or your eligible dependents gain access to new QHPs or other individual coverage as a result of a permanent move.

8. You and/or your eligible dependents are enrolled in an individual non-calendar year health insurance policy. You and/or your eligible dependents limited open enrollment period begins on the date that is 30 calendar days prior to the date the policy year ends.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the guidelines as established by Blue Cross and Blue Shield.

This section "Limited Enrollment Periods/Effective Date of Coverage" is subject to change by Blue Cross and Blue Shield, and/or applicable law, as appropriate.

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 dependents. You must apply for coverage within 60 days from the date of a special enrollment event. Coverage for you and your eligible dependents will be effective the 1st day of the calendar month beginning after the special enrollment event.

Special Enrollment Events:

1. Upon your death;
2. The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of your employment;
3. Legal separation, divorce, or dissolution of a Civil Union or termination of a Domestic Partnership;
4. A dependent child ceases to be a dependent child under the generally applicable requirements of the Policy;

5. Loss of coverage through an HMO in the individual market because you and/or your eligible dependents no longer resides, lives or works in the service area;
6. Loss of coverage through an HMO, or other arrangement, in the group market because you and/or your eligible dependents no longer reside, live or work in the network service area, and no other coverage is available to you and/or your eligible dependents;
7. You and/or your eligible dependents incur a claim that would meet or exceed a lifetime limit on all benefits;
8. Loss of coverage due to a policy no longer offering benefits to the class of similarly situated individuals that include you and/or your eligible dependents;
9. Your and/or your eligible dependent's Employer ceases to contribute towards your or your dependent's coverage (excluding COBRA continuation coverage);
10. COBRA continuation coverage is exhausted.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the guidelines as established by Blue Cross and Blue Shield.

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

WHO IS NOT ELIGIBLE

The following individuals are not eligible for this coverage:

1. Unless listed as an eligible dependent, no other family member, Domestic Partner, common-law spouse, relative, or person is eligible for coverage under this Policy;
2. Incarcerated individuals, other than incarcerated individuals pending disposition of charges;
3. Individuals that do not live, reside or work in the network service area; and
4. Individuals that do not meet Blue Cross and Blue Shield's eligibility requirements or residency standards.

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

WHEN COVERAGE BEGINS

This Policy does not cover any service received before your effective date of coverage. Also, if your prior coverage has an extension of benefits provision, this Policy will **not** cover charges incurred after your effective date that are covered under the prior plan's extension of benefits provision.

NOTIFICATION OF ELIGIBILITY CHANGES

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

RESCISSION OF COVERAGE

Any act, practice, or omission that constitutes fraud, or any intentional misrepresentation made by or on behalf of anyone seeking coverage under this Policy, may result in the cancellation of your coverage (and/or your dependent(s) coverage) retroactive to the effective date, subject to 30 days prior notification. Rescission is defined as cancellation or discontinuance of coverage that has a retroactive effect, except to the extent attributable to a failure to timely pay premiums. In the event of such cancellation, Blue Cross and Blue Shield may deduct from the premium refund any amounts made in Claim payments during this period and you may be liable for any Claims payment amount greater than the total amount of premiums paid during the period for which cancellation is effected. At any time when Blue Cross and Blue Shield is entitled to rescind coverage already in force, Blue Cross and Blue Shield may at its option make an offer to reform the Policy already in force or is otherwise permitted to make retroactive changes to this Policy and/or change the rating category/level. In the event of reformation, the Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application. You have 180 days to appeal a Rescission or reformation of coverage. Please refer to the section *How To File a Claim* for information about your appeal rights concerning Rescission and/or reformation.

YOUR SCHEDULE PAGE

A Schedule Page has been inserted into and is part of this Policy. The Schedule Page contains specific information about your coverage including, but not limited to:

- Whether you have Individual Coverage or Family Coverage;
- The amount of your Deductible(s), and/or Copayment(s), and/or Coinsurance amount;
- The Hospital and Physician benefit payment levels; and
- The premium amount and the method of payment.

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

If you have Family Coverage, your health care expenses and those of your enrolled spouse and your (or your spouse's) enrolled children who are under age 26 will be covered. All of the provisions of this Policy that pertain to a spouse also apply to a party of a Civil Union. A Domestic Partner and his/her children who are under age 26 are also eligible dependents. All of the provisions of this Policy that pertain to a spouse also apply to a Domestic Partner unless specifically noted otherwise.

"Child(ren)" used hereafter, means a natural child(ren), a stepchild(ren), 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 child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors.

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

- Live within the Blue Cross and Blue Shield's service area; and
- Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
- Have received a release or discharge other than a dishonorable discharge.

Coverage for enrolled unmarried college students will continue to be provided for up to 12 months if he/she takes a medical leave of absence or reduces his/her course load to part-time status because of a serious illness or injury. Such continuation of coverage because of a serious illness or injury will terminate 12 months after notice of the illness or injury.

Newborn children will be covered from the moment of birth. Please notify Blue Cross and Blue Shield within 60 days of the birth so that your membership records can be adjusted.

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

Children who are under your legal guardianship or who are in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, will be covered. In addition, if you have children who are not living with you but for whom you are required by law to provide health care coverage, those children will be covered.

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

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

PAYMENT OF PREMIUMS

a. Premiums are due and payable on the due date.

b. The initial premium for Individual Coverage is based on your age at the time your coverage begins and the initial premium for Family Coverage is based on your age, your spouse's age and any eligible dependent children at the time coverage is applied for, as permitted by law.

c. Blue Cross and Blue Shield may establish a new premium for any of the benefits of this Policy on any of the following dates or occurrences:

1. whenever the benefits of this Policy are increased, which may occur whenever required by applicable law or as directed by regulatory interpretation;
2. whenever the number of persons covered under this Policy is changed;
3. whenever you move your residence from one geographical rating area to another.
4. whenever there is a change in your eligible dependent;s tobacco use.

d. If the ages upon which the premium is based have been misstated, an amount which will provide Blue Cross and Blue Shield with the correct premium from your Coverage Date shall be due and payable upon billing or receipt from Blue Cross and Blue Shield.

e. In the event you are not receiving an Advanced Premium Tax Credit, a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the Policy shall continue in force. After a grace period of 31 days, coverage under this Policy will automatically terminate on the last day of the coverage period for which premiums have been paid, unless coverage is extended as described below.

f. In the event you are receiving an Advance Premium Tax Credit, you have a three-month grace period for paying the full premiums falling due after the first premium. If full premium is not paid for you and your eligible dependents within one month of the premium due date, claim payments for Covered Services received during the second and third month's grace period under this Policy will be pended until full premium payment is made. If full payment of the premium is not made within the three-month grace period, then coverage under this Policy will automatically terminate on the last day of the first month of the three-month grace period. During the grace period, Blue Cross and Blue Shield will:

   - pay all appropriate claims for services rendered during the first month of the grace period and may pend claims for services rendered in the second and third months of the grace period;
   - notify the Department of Health and Human Services of such non-payment; and
   - notify Providers of the possibility of denied claims during the second and third months of your grace period.

The required premiums are determined and established by Blue Cross and Blue Shield based on your age, place of residence, tobacco use, and the number of dependents covered under this Policy according to the schedules filed with the Illinois Department of Insurance. Premiums will be calculated based on the age of each individual to be included under this Policy.

Note: A Tobacco User may be subject to a premium increase of up to 1.5 times the rate applicable to those who are not Tobacco Users, to the extent permitted by applicable law.

Your premium will not be adjusted more often than annually except for:

— As a result of changes to or as otherwise expressly permitted by state or federal laws and regulations;

— Changes to coverage classification (for example, to a new age category or geographic location, for a change from non-smoking to a smoking category, or from a single family member coverage to a two family member coverage type); or

— After giving you 60 days written notice.

If premium is paid beyond the effective date of the premium change, Blue Cross and Blue Shield may require you to pay an additional premium or accept a refund (whichever is necessary). Premium payments should be sent to:

Blue Cross and Blue Shield of Illinois
P. O. Box 3240
Naperville, IL 60566- 7240

When Premiums Are Not Paid on Time

A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the Policy shall continue in force. After a grace period of 31 days, coverage under this Policy will automatically terminate on the last day of the coverage period for which premiums have been paid, unless coverage is extended.

Refund Policy

You have the right to read this Policy and if not satisfied for any reason, may return it to Blue Cross and Blue Shield within 30 days from the date it was sent to you. Blue Cross and Blue Shield will refund to you all premiums you paid for that 30-day period. However, Blue Cross and Blue Shield has the right to recover any benefit payments made for Claims during that 30-day period. Otherwise, premiums for coverage are **not** refundable unless you have paid premi-

ums in advance and wish to cancel coverage (with 30 days prior notice) or in the case of the the death of a member. The one time application fee, if any, is also non-refundable.

REMOVING AN INDIVIDUAL FROM COVERAGE

To remove a family member from coverage, you must submit a request to Blue Cross and Blue Shield. You may re-enroll these terminated individuals under this Policy only during the enrollment periods. Application(s) must be completed and signed by you, and submitted to and approved by Blue Cross and Blue Shield.

If an individual is being removed from coverage because of losing his/her eligibility under this Policy, the individual is eligible to enroll under this Policy only during the enrollment periods, as applicable, by submitting an Application(s) to Blue Cross and Blue Shield and the Providers of care may recover benefits erroneously paid to you on behalf of the removed member during the period of time during which the individual was ineligible.

REINSTATEMENT

Any applicant whose previous Blue Cross and Blue Shield contract was terminated for good cause is eligible to re-enroll in this Policy, only during the open enrollment and special enrollment period, as applicable, by submitting Application(s) to Blue Cross and Blue Shield.

When coverage lapses because you have not paid the premium, the terminated member(s) can apply for reinstatement of coverage by sending in the appropriate premium due. If you have included the necessary payment and no more than 60 days have elapsed since termination due to nonpayment of premium, coverage will be reinstated back to the date coverage lapsed. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of the reinstatement and loss due to such sickness as may begin more than 10 days after such date.

If more than 60 days have elapsed since coverage was terminated, you will have to complete a new Application(s) for each family member applying for coverage. Blue Cross and Blue Shield may accept or deny the Application(s). You will be notified within 30 days of receipt of application of acceptance or declination of reinstatement. If notice is not sent within 30 days, reinstatement will be deemed approved.

TERMINATION OF COVERAGE/WHEN COVERAGE ENDS

If your coverage is terminated for any reason, Blue Cross and Blue Shield will provide you with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage.

This Policy is renewable at your option, unless coverage under this Policy is 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 premium payment on time or when there is a bank draft failure of premiums for your and/or your eligible dependents' coverage, and
   - After the 31-day grace period has been exhausted, the last day of coverage will be the last day of the 31-day grace period. Also, if coverage is terminated, any Claims received and paid for during the 31-day grace period will be billed to you. Blue Cross and Blue Shield applies its termination policy for non-payment of premium uniformly to enrollees in similar circumstances.
3. On the day when there is a material failure to abide by the rules, policies or procedures of the Policy; or intentional fraud or material misrepresentation affecting coverage. If you knowingly gave false material information in connection with the eligibility or enrollment of yourself or any of your eligible dependents, Blue Cross and Blue Shield may terminate your or your dependents coverage retroactively to the date of initial enrollment. You are liable for any benefit payments made as a result of such improper actions.
4. Blue Cross and Blue Shield ceases to offer coverage in the individual market in accordance with applicable law. Blue Cross and Blue Shield shall:
   - Provide written notice to the applicable state authority and to you of the discontinuation at least 180 days prior to the date the coverage will be discontinued;
   - Discontinue and not renew all health insurance policies issued or delivered for issuance in the state in the individual market.
5. You no longer live, reside or work in Blue Cross and Blue Shield's service area or network service area.
6. Blue Cross and Blue Shield discontinues offering a particular product offered in the individual market. Blue Cross and Blue Shield shall:
   - Provide notice to you of the discontinuation at least 90 calendar days before the date the coverage will be discontinued;

- Offer to you to purchase other health insurance coverage currently being offered by Blue Cross and Blue Shield to individuals in the individual market; and
- Act uniformly without regard to your or your dependent's claims experience or health status.

7. Your coverage has been rescinded.

If Blue Cross and Blue Shield ceases operations, Blue Cross and Blue Shield will be obligated for services for the rest of the period for which premiums were already paid.

Cancellation of your coverage under this Policy terminates the coverage of all your dependents under this Policy.

Except for nonpayment of premium, Blue Cross and Blue Shield will not terminate your coverage without giving you 30 days written notice. Also, if your coverage is cancelled (for reasons other than fraud or deception) and you have paid premium in advance on behalf of the affected member, Blue Cross and Shield will return to you, within 30 days, the appropriate pro rata portion of the premium, less any amounts due to Blue Cross and Blue Shield.

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

Extension of Benefits in Case of Discontinuance of Coverage

If you are Totally Disabled at the time this Policy terminates, benefits will be provided for (and limited to) the Covered Services described in this Policy which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's policy due to the absence of coverage in the policy. Benefits will be provided for a period of no more than 12 months from the date of termination. These benefits are subject to all of the terms and conditions of this Policy including, but not limited to, the requirements regarding Primary Care Physician referral. 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 your disability. This extension of benefits does not apply to the Outpatient Prescription Drug Program Benefits Section of this Policy.

CONTINUATION OF COVERAGE FOR INELIGIBLE DEPENDENTS

Continuation of coverage applies when a person who is covered under this Policy becomes ineligible but wishes to continue his/her coverage. Continuation of coverage is only available:

a. to a spouse and/or dependent children upon the Enrollee's death or upon divorce from the Enrollee. The spouse may enroll under Family Coverage and include any dependent children under that coverage or the spouse and each child may enroll under separate Individual Coverages.

b. to a dependent child who becomes ineligible because of reaching the dependent limiting age. Such dependent may enroll under his/her own Individual Coverage.

If you want to continue your coverage, contact Blue Cross and Blue Shield for an application. Blue Cross and Blue Shield must receive your completed application within 31 days of the date that you became ineligible.

CHILD-ONLY COVERAGE

Eligible children that have not attained age 21 may enroll as the sole enrollee under this health care plan. In such event, this benefit program is considered child-only coverage and the following restrictions apply:

- Each child is enrolled individually as the sole enrollee; the parent or legal guardian is not covered and is not eligible for benefits under this benefit program.
- No additional dependents may be added to the enrolled child's coverage. Each child must be enrolled in his/her own plan. **Note: If a child covered under this benefit program acquires a new eligible child of his/her own, the new eligible child may be enrolled in his/her own coverage if application for coverage is made within 60 days.**
- If a child is under the age of 18, his/her parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and/or other required information to Blue Cross and Blue Shield. For any child under 18 covered under this benefit program, any obligations set forth in this Policy, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Application for child-only coverage will not be accepted for an adult child that has attained age 21 as of the beginning of the plan year. Adult children (at least 18 years of age but have not attained the age of 21) who are applying as the sole enrollee under this Policy must apply for their own individual Policy and must sign or authorize the application(s).

YOUR PRIMARY CARE PHYSICIAN

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

As a participant in this benefit program, a directory of Participating Individual Practice Associations (IPAs) or Participating Medical Groups is available to you. You can visit the Blue Cross and Blue Shield Web site at *www.bcbsil.com* for a list of Participating IPAs/Participating Medical Groups or you can contact Member Services and request a copy of the Provider Directory and one will be sent to you.

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

Your Primary Care Physician is responsible for coordinating all of your health care needs. In the case of female members, your health care needs may be coordinated by your Primary Care Physician and/or your Woman's Principal Health Care Provider. In the case of a dispute between your Primary Care Physician or Woman's Principal Health Care Provider and Blue Cross and Blue Shield regarding the medical necessity of services provided to you, please contact your Participating IPA/Participating Medical Group. Your Participating IPA/Participating Medical Group has processes in place to resolve disputes between your Primary Care Physician or Woman's Principal Health Care Provider and Blue Cross and Blue Shield.

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

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

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

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

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

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

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

Changing Your Participating IPA/Participating Medical Group

You may change from your Participating IPA/Participating Medical Group to another Participating IPA/Participating Medical Group by calling Blue Cross and Blue Shield at 1-800-892-2803.

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

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

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

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

Changing Your Woman's Principal Health Care Provider

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

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

After-Hours Care

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

Transition of Care Benefits

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

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

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

YOUR OVERALL PROGRAM DEDUCTIBLE

If you have Individual Coverage, each calendar year you must satisfy the deductible amount(s) shown on your Schedule Page, if any, before receiving benefits.

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

The deductible amount is subject to change or increase as permitted by applicable law.

If you changed carriers during the calendar year, the expenses you incurred which were applied towards the deductible for services covered by the prior carrier will be applied to the deductible of your initial program deductible under this Policy.

PHYSICIAN BENEFITS

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

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

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

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

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

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

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

The following services are also part of your surgical benefits:

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

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

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

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

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

Medical Care

Benefits will be provided for Medical Care rendered to you:

— when you are an Inpatient in a Hospital, Skilled Nursing Facility or a Residential Treatment Center;

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

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

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

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

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

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

— one baseline mammogram

— an annual mammogram

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

If a mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening of an entire breast or breasts as determined by your Primary Care Physician or Woman's Principal Health Care Provider. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Policy.

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

PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided in this Policy, (and notwithstanding anything in your Policy to the contrary), the following preventive care services will be considered Covered Services when ordered by your Primary Care Physician or Woman's Principal Health Care Provider and will not be subject to any calendar year deductible, Coinsurance, Copayment or benefit dollar maximum:

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 a. above, as provided for in comprehensive guidelines supported by the HRSA.

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

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

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, the Plan may use reasonable medical management techniques to determine coverage.

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

Preventive Care Services for Adults:

1. Abdominal aortic aneurysm screening for men who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults over age 50

7. Depression screening
8. Type 2 diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human papillomavirus
    - Influenza (Flu shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
12. Obesity screening and counseling
13. Sexually transmitted infections (STI) prevention
14. Tobacco use screening and cessation interventions for Tobacco Users
15. Syphilis screening for adults at higher risk
16. Physical Therapy to prevent falls in adults age 65 years and older who are at increased risk for falls
17. Hepatitis C virus (HCV) screening for persons at high risk for infection
18. One time HCV screening for adults born between 1945 and 1965

Preventive Care Services for Women (including pregnant women):

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract screening or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Breast cancer mammography screenings
5. Breast cancer chemoprevention counseling for women at higher risk
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
7. Cervical cancer screening for sexually active women
8. Chlamydia infection screening for younger women and women at higher risk
9. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs, except when the life of the mother would be endangered if the fetus were carried to term
10. Domestic and interpersonal violence screening and counseling for all women
11. Folic acid supplements for women who may become pregnant
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. HIV screening and counseling for sexually active women and pre-natal HIV testing
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 60, depending on risk factors
18. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Sexually transmitted infections (STI) counseling for sexually active women
21. Syphilis screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services.
23. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence and device removal
24. Hepatitis C virus (HCV) screening for women at high risk for infection

Preventive Care Services for Children:

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 sexually active females
5. Congenital hypothyroidism screening for newborns
6. Depression screening for adolescents
7. Development screening for children under age 3, and surveillance throughout childhood
8. Dyslipidemia screening for children at higher risk of lipid disorder
9. Fluoride chemoprevention supplements for children without fluoride in their water source
10. Gonorrhea preventive medication for the eyes of all newborns
11. Hearing screening for all newborns
12. Height, weight and body mass index measurements
13. Hematocrit or hemoglobin screening
14. Hemoglobinopathies or sickle cell screening for all newborns
15. HIV screening for adolescents at higher risk
16. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Hepatitis C virus (HCV)
    - Human papillomavirus
    - Influenza (Flu shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
    - Haemophilus influenzae type b
    - Rotavirus
17. Iron supplements for children ages 6 to 12 months at risk for anemia
18. Lead screening for children at risk for exposure
19. Autism screening
20. Medical history for all children throughout development

21. Obesity screening and counseling
22. Oral health risk assessment for younger children up to ten years old
23. Phenylketonuria (PKU) screening for newborns
24. Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk
25. Tuberculin testing for children at higher risk of tuberculosis
26. Vision screening for all children
27. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision

The FDA-approved contraceptive drugs and devices currently covered under this benefit provision are listed on the Contraceptive Drugs & Devices List. This list is available on our Web site at *www.bcbsil.com* and by contacting customer service at the toll-free number on your identification card. Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the Contraceptive Drugs & Devices List. You may, however, have coverage under other sections of this Policy, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The Contraceptive Drugs & Devices 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.

Routine pediatric care, women's preventive care (such as contraceptives) and/or Outpatient periodic health examinations Covered Services not included above will be subject to the deductible, Coinsurance, Copayments and/or benefit maximums previously described in your Policy, if applicable.

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

Covered Services include, but are not limited to:

— clinical breast examinations;

— routine cervical smears or Pap smears;

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

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

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

Benefits will also be provided for pre-marital examinations that are required by state or federal law. Benefits are not available for examinations done for insurance or employment screening purposes. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Policy.

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

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

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

Allergy Testing and Treatment

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

In addition, benefits will be provided for a human papillomavirus (HPV) vaccine and a shingles vaccine approved by the federal Food and Drug Administration. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Policy.

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

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

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

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

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

Cancer Medications — Benefits will be provided for orally administered cancer medications, intravenously administered cancer medications or injected cancer medications that are used to kill or slow the growth of cancerous cells.

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

Cardiac Rehabilitation Services — Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization. Benefits for Cardiac Rehabilitation Services are subject to the combined calendar year maximum for Outpatient Rehabilitative Therapy described above.

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

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

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

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

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

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

Chiropractic and Osteopathic Manipulation — Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Benefits for chiropractic and osteopathic manipulation are limited to 25 visits per calendar year.

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

Diabetes Self-Management Training and Education — Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits are also available for regular foot care examinations by a Physician or Podiatrist. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Policy.

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

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

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

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

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

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

Outpatient Contraceptive Services — Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Policy.

Bone Mass Measurement and Osteoporosis — Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Policy.

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

Infertility Treatment

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

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

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

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

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

condition that renders such treatment useless). Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per calendar year.

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

If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count as one completed oocyte retrieval. Following the fourth completed oocyte retrieval in a calendar year, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you.

Benefits will not be provided for the following:

1. Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of "infertility" as stated above.
2. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
3. Selected termination of an embryo in cases where the mother's life is not in danger.
4. Cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
5. Non-medical costs of an egg or sperm donor.
6. Travel costs for travel within 100 miles of the covered person's home or which is not medically necessary or which is not required by Blue Cross and Blue Shield.
7. Infertility treatments which are determined to be Investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology.
8. Infertility treatment rendered to your dependents under the age of 18.

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

Mastectomy Related Services

Benefits will be provided for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) post mastectomy care for Inpatient treatment for a length of time determined by the attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation, and a follow-up Physician office visit or in-home nurse visit within forty-eight (48) hours after discharge; and 4) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; 5) the removal of breast implants when the removal of the implants is a medically necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic Surgery.

Maternity Services

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

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

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

except as may be indicated by the following: A shorter length of hospital Inpatient stay related to maternity and newborn care may be provided if the attending physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetrics and Gynecology or by the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother and new-

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

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

URGENT CARE

This benefit provides medically necessary outpatient care if you are outside the Blue Cross and Blue Shield's service area and experience an unexpected illness or injury that would not be considered an Emergency Condition, but which should be treated before returning home. Services usually are provided at a Physician's office. If you require such urgent care, you should contact your Participating IPA/Participating Medical Group. You will be given the names and addresses of nearby participating Physicians and Hospitals that you can contact to arrange an appointment for urgent care.

Your Cost for Urgent Care Treatment

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

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

FOLLOW-UP CARE

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

Your Cost for Follow-Up Care Treatment

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

YOUR COST FOR PHYSICIAN SERVICES

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

Benefits for all Outpatient office visits, except for Outpatient periodic health examinations, preventive care services, routine pediatric care, routine vision examinations, rehabilitative therapy, the treatment of Mental Illness other than Serious Mental Illness, Surgery, and maternity services after the first pre-natal visit are subject to the Copayment amount shown on your Schedule Page per visit, unless otherwise specified in this Policy, and then will be paid in full at no cost to you when such services are received from a:

- Physician
- Physician Assistant
- Certified Nurse Midwife
- Certified Nurse Practitioner
- Certified Registered Nurse Anesthetist
- Certified Clinical Nurse Specialist
- Marriage and Family Therapist

Benefits for Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy are subject to the Copayment amount shown on your Schedule Page per visit, unless otherwise specified in this Policy, and then will be paid in full at no cost to you.

Benefits for all Outpatient Diagnostic Services are subject to the Copayment amount shown on your Schedule Page per procedure, unless otherwise specified in this Policy, and then will be paid in full at no cost to you.

Benefits for all Outpatient CT Scans, MRIs, and PET Scans are subject to the Copayment amount shown on your Schedule Page per procedure, unless otherwise specified in this Policy, and then will be paid in full at no cost to you.

Benefits for Outpatient office visits to a Specialist Physician's office are subject to the separate Copayment amount shown on your Schedule Page and then will be paid in full at no cost to you.

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

HOSPITAL BENEFITS

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

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

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

COVERED SERVICES

Inpatient Benefits

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

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

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

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

Number of Inpatient Days

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

Outpatient Benefits

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

1. **Surgery** — when performed in a Hospital or Ambulatory Surgical Facility. Benefits for Surgery also include Surgery for morbid obesity (including, but not limited to bariatric Surgery).
2. **Diagnostic Services** — that is, tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury.
3. **Radiation Therapy** — that is, the use of ionizing radiation in the treatment of a medical illness or condition.
4. **Chemotherapy** — that is, the treatment of malignancies with drugs.
5. **Electroconvulsive Therapy**
6. **Renal Dialysis Treatments and Continuous Ambulatory Peritoneal Dialysis Treatment** — when received in a Hospital or a Dialysis Facility. Benefits for treatment in your home are available if you are homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and are rendered under the supervision of a Hospital or Dialysis Facility health care professional.

Special Programs

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

1. **Coordinated Home Care Program**
2. **Pre-Admission Testing** — This is a program in which preoperative tests are given to you as an Outpatient in a Hospital to prepare you for Surgery that you are scheduled to have as an Inpatient.
3. **Partial Hospitalization Treatment Program** — This is a therapeutic treatment program in a Hospital for patients with Mental Illness.
4. **Tobacco Use Cessation Program**

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

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

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

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

Surgical Implants

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

Maternity Services

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

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

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

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

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

URGENT CARE

This benefit provides medically necessary outpatient care if you are outside the Blue Cross and Blue Shield's service area and experience an unexpected illness or injury that would not be considered an Emergency Condition, but which should be treated before returning home. Services usually are provided at a Physician's office. If you require such urgent care, you should contact your Participating IPA/Participating Medical Group. You will be given the names and

addresses of nearby participating Physicians and Hospitals that you can contact to arrange an appointment for urgent care.

Your Cost for Urgent Care Treatment

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

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

FOLLOW-UP CARE

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

Your Cost for Follow-Up Care Treatment

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

YOUR COST FOR INPATIENT HOSPITAL SERVICES

Covered Services for Inpatient Hospital Services will be paid in full, with no cost to you, except as shown on your Schedule Page, after you have met your program deductible.

Each time you are admitted as an Inpatient to a Hospital, Skilled Nursing Facility or Residential Treatment Center, you must satisfy the deductible amount as shown on the Schedule Page, if any. The Inpatient admission deductible is a separate deductible from the program deductible. However, if your admission to a Skilled Nursing Facility or Residential Treatment Center immediately follows an Inpatient Hospital stay, then the Inpatient admission deductible will not apply to such admission. After you have satisfied the program deductible and the Inpatient admission deductible, benefits for Covered Services will be paid at the Coinsurance amount shown on the Schedule Page, if any.

YOUR COST FOR OUTPATIENT HOSPITAL SERVICES

Covered Services for Outpatient Hospital Services are covered in full, with no cost to you, except as specifically mentioned below.

When you receive Covered Services for Outpatient Surgery, you are responsible for paying the Copayment amount as shown on your Schedule Page per visit, then benefits will be paid in full.

SUPPLEMENTAL BENEFITS

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

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

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

- **Blood and Blood Components**
- **Outpatient Private Duty Nursing Service**—Benefits for Outpatient Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care Provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Outpatient Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Outpatient Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- **Medical and Surgical Dressings, Supplies, Casts and Splints**
- **Oxygen and its administration**
- **Naprapathic Service** — Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of 15 visits per calendar year.
- **Prosthetic Devices**—benefits will be provided for prosthetic devices, special appliances and surgical implants required for an illness or injury when:
  a. they are required to replace all or part of an organ or tissue of the human body; or
  b. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

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

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

YOUR COST FOR COVERED SERVICES

You are responsible for the Coinsurance amount shown on your Schedule Page, if any, for the Covered Services specified above after you have met your program deductible, if any.

EMERGENCY CARE BENEFITS

This section of your Policy explains your emergency care benefits.

Notwithstanding anything in your Policy to the contrary, for emergency care benefits rendered by Providers who are not part of your HMO's network or otherwise contracted with your HMO, you will not be responsible for any charges that exceed the amount negotiated with Providers for emergency care benefits furnished.

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

IN-AREA TREATMENT OF AN EMERGENCY

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

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

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

Your Cost for an In-Area Emergency Treatment

Benefits for emergency treatment received in your Participating IPA's/Participating Medical Group's treatment area will be paid as shown on your Schedule Page.

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for the deductible amount shown on the Schedule Page. Thereafter, you will be responsible for paying the Coinsurance amount shown on your Schedule Page, after you have met your program deductible, if applicable. However, the emergency room deductible does not apply to services provided for the treatment of criminal sexual assault.

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

OUT-OF-AREA TREATMENT OF AN EMERGENCY

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

Your Cost for an Out-of-Area Emergency Treatment

Benefits for emergency treatment received outside of your Participating IPA's/Participating Medical Group's treatment area will be paid as shown on your Schedule Page.

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for the deductible amount shown on the Schedule Page. Thereafter, you will be responsible for paying the Coinsurance amount shown on your Schedule Page, after you have met your program deductible, if applicable. However, the emergency room deductible does not apply to services provided for the treatment of criminal sexual assault.

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

EMERGENCY AMBULANCE BENEFITS

Benefits for emergency ambulance transportation are available when:

a. such transportation is ordered by your Primary Care Physician or Woman's Principal Health Care Provider; or

b. the need for such transportation has been reasonably determined by a Physician, public safety official or other emergency medical personnel rendered in connection with an Emergency Condition.

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

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

SUBSTANCE USE DISORDER TREATMENT BENEFITS

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

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

INPATIENT BENEFITS

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

BENEFIT PAYMENT FOR INPATIENT BENEFITS

Each time you are admitted as an Inpatient to a Hospital, Substance Use Disorder Treatment Facility or Residential Treatment Center, you are responsible for paying the deductible amount shown on your Schedule Page, after you have met your program deductible, if any. After the deductible, benefits for Covered Services will be paid as shown on your Schedule Page.

COST TO YOU FOR OUTPATIENT BENEFITS

Benefits for Outpatient office visits for Substance Use Disorder Treatment are subject to the Copayment amount shown on your Schedule Page per visit and then will be paid at 100% of the Provider's Charge.

However, benefits for Outpatient Substance Use Disorder Treatment visits to a Specialist Physician's office are subject to the Copayment amount shown on your Schedule Page per visit and then benefits for Covered Services will be paid at 100% of the Provider's Charge.

Detoxification

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

HUMAN ORGAN TRANSPLANT BENEFITS

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

All of the benefits specified in the other benefit sections of this Policy are available for Surgery performed to transplant an organ or tissue. In addition, benefits will be provided for transportation of the donor organ to the location of the transplant Surgery, limited to transportation in the United States or Canada. Benefits will also be available for immunosuppresive drugs, donor screening and identification costs, under approved matched unrelated donor programs. Payment for Covered Services received will be the same as that specified in those benefit sections. If there is a change that alters the terms of coverage for prescribed immunosuppressive drugs, the Plan shall notify you or your authorized representative along with your prescribing Physician least 60 days prior to making such change. The notice shall describe the change and include information your prescribing Physician's right to appeal such change.

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

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

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

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

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

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

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

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

HOSPICE CARE BENEFITS

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

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

The following services are covered under the Hospice Care Program:

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

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

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

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

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

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. Benefits will not be provided for any self-administered drugs dispensed by a Physician. This section of your Policy explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are medically necessary as determined by your Primary Care Physician or Woman's Principal Health Care Provider.

Although you can go to the Pharmacy of your choice, benefits will only be provided for drugs and supplies when purchased through a Participating Pharmacy in Illinois. Benefits for drugs and supplies when purchased outside of Illinois will only be provided in the case of an emergency condition. You can visit Blue Cross and Blue Shield's Web site at *www.bcbsil.com* for a list of Participating Pharmacies or call the Customer Service toll-free number on your identification card. The Pharmacies that are Participating Pharmacies may change from time to time. You should check with your Pharmacy before obtaining drugs or supplies to make certain of its participation status.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with the Plan or the entity chosen by the Plan to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider

which does not have a written agreement with the Plan or the entity chosen by the Plan to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

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

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

FORMULARY BRAND NAME DRUG……means a brand name prescription drug product that is identified on the *Drug List* as a Formulary Brand Name Drug and is subject to the Formulary Brand Name Drug payment level. This list is available by accessing the Web site at *www.bcbsil.com*.

GENERIC DRUG.....means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding payment level, the Plan utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. "High-cost" Generic Drugs are those former Brand Name Drugs that have more recently been allowed to be produced as Generic; "low-cost" Generic Drugs are those drugs that have been available for sale as Generic for longer periods of time. A list of Generic Drugs is available on the Plan's Web site at *www.bcbsil.com* You may also contact customer service at the toll-free number indicated on the back of your identification card.

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

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

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

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

NON-FORMULARY BRAND NAME DRUG.....means a Brand Name Drug that is identified on the *Drug List* as a Non-Formulary Brand Name Drug and is subject to the Non-Formulary Brand Name Drug payment level. This *Drug List* is available by accessing the Web site at *www.bcbsil.com*.

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

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

PHARMACY.....means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

PRESCRIPTION ORDER.....means a written or verbal order from a Health Care Practitioner to a pharmacist for a drug to be dispensed. Orders written by a Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under this Benefit Section.

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

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

ABOUT YOUR BENEFITS

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 drugs regulated by the FDA for inclusion on the *Drug List*. As part of the process, the committee reviews data from clinical studies, published literature and opinions from experts who are not part of the committee. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the *Drug List*.

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

The *Drug List* and any modifications will be made available to you. Blue Cross and Blue Shield may offer multiple formularies. By accessing the Web site at *www.bcbsil.com* or calling the Customer Service toll-free number on your identification card, you will be able to determine the *Drug List* that applies to you and whether a particular drug is on the *Drug List*. Drugs that appear on the *Drug List* as Non-Formulary Brand Name Drugs are subject to the Non-Formulary Brand Name Drug payment level plus any pricing differences that may apply to the Covered Drug you receive.

PRIOR AUTHORIZATION/STEP THERAPY REQUIREMENT

When certain medications and drug classes, such as medications used to treat rheumatoid arthritis, growth hormone deficiency, hepatitis C, and more serious forms of anemia, hypertension, asthma, epilepsy and psoriasis are prescribed, you will be required to obtain authorization from the Plan in order to receive benefits. Medications included in this program are subject to change and other medications for other conditions may be added to the program. Although you may currently be on therapy, your Claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the brand name medication.

The Plan's prescription drug administrator will send a questionnaire to your Physician upon your or your Pharmacy's request. The questionnaire must be returned to the prescription drug administrator who will review the questionnaire and determine whether the reason for the prescription meets the criteria for medically necessary care. You and your Physician will be notified of the prescription drug administrator's determination. Although there is no penalty if you do not obtain authorization prior to purchasing the medication, you are strongly encouraged to do so, to help you and your doctor factor your cost into your treatment decision. If criteria for medical necessity is not met, coverage will be denied and you will be responsible for the full charge incurred.

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

Dispensing Limits

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

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

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

Day Supply

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

Controlled Substances Limitation

If Blue Cross and Blue Shield determines that you may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized treatment guidelines, any additional drugs may be subject to a review for medical necessity, appropriateness and other coverage restrictions such as limiting coverage to services provided by a certain Provider and/or Participating Pharmacy for the prescribing and dispensing of the controlled substance medication.

Pharmaceutical Manufacturer Discount Limitation

Benefits for prescription medications purchased with manufacturer discounts may not be covered by the Plan if other therapeutic alternative medications are available. To determine if a specific drug is subject to this limitation, you should contact your Pharmacy or access the Web site at *www.bcbsil.com* or call the customer service toll-free number on the back of your identification card.

COVERED SERVICES

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

1. Has been approved by the FDA for at least one indication; and
2. Is recognized by substantially accepted peer-reviewed medical literature for treatment of the indication for which the drug is prescribed.

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

The Coinsurance or Copayment Amount shown on your Schedule Page will apply to each fill of a medication having a unique strength, dosage, or dosage form.

Injectable Drugs

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

Fertility Drugs

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

Diabetic Supplies for Treatment of Diabetes

Benefits are available for medically necessary items of diabetic supplies and blood glucose monitors (including non-invasive monitors and monitors for the blind) for which a Health Care Practitioner has written an order. Such diabetes supplies shall include, but are not limited to, the following:

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

90-Day Supply Prescription Drug Program

The 90-Day Supply Prescription Drug Program provides delivery of Covered Drugs directly to your home address. In addition to the benefits described in this benefit section, your coverage includes benefits for Maintenance Drugs and diabetic supplies obtained through the 90-Day Supply Prescription Drug Program. For information about this program, contact Blue Cross and Blue Shield or visit our Web site at *www.bcbsil.com*.

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

on your identification card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

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

Specialty Pharmacy Program

This program provides delivery of medications directly to your Health Care Practitioner, administration location or to your home if you are undergoing treatment for a complex medical condition. Due to special storage requirements and high cost, Specialty Drugs are not covered unless obtained through the Specialty Pharmacy Program. To determine which drugs are Specialty Drugs or to locate a Specialty Pharmacy Provider, you should refer to the *Drug List* by accessing the Web site at *www.bcbsil.com* or call the Customer Service toll-free number on your identification card.

The Specialty Pharmacy Program delivery service offers:

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

YOUR COST FOR PRESCRIPTION DRUGS

30-Day Supply Prescription Drug Program

Benefit payment for the 30-day supply prescription drug program

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

When you purchase drugs or diabetic supplies from a Participating Prescription Drug Provider, you will not be charged any amount other than the specified amounts shown on your Schedule Page. You will be charged the appropriate amount for each prescription.

One prescription means up to a 30 consecutive day supply for most medications. Certain drugs may be limited to less than a 30 consecutive day supply. However, for certain maintenance type drugs, larger quantities may be obtained through the 90-day supply prescription drug program. Specific information on these maintenance drugs can be obtained from a Prescription Drug Provider participating in the 90-day supply prescription drug program or the Plan. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

No benefits will be provided when you purchase drugs or diabetic supplies from a Non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider) in Illinois. However, if the Non-Participating Prescription Drug Provider is located outside of Illinois, then benefits for drugs or diabetic supplies purchased for emergency conditions will be provided and you will be responsible for the specified Coinsurance or Copayment amount shown on your Schedule Page. You will be charged the appropriate Coinsurance or Copayment amount for each prescription.

90-Day Supply Prescription Drug Program

Benefit payment for the 90-day supply prescription drug program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs and diabetic supplies which may be purchased through a retail or mail order Pharmacy participating in the 90-day supply prescription drug program. You will not be charged any amount other than the appropriate Coinsurance or Copayment amount, specified on your Schedule Page. There is no charge to you for diabetic supplies.

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

Should you choose to obtain a 90-day supply Prescription Order from a mail order Pharmacy, you can obtain an order form from Blue Cross and Blue Shield.

EXCLUSIONS

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

1. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels and vaccinations administered through certain Participating Pharmacies,); and drugs or covered devices for which no valid Prescription Order is obtained.
2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, male contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).
3. Administration or injection of any drugs.
4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
5. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
7. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Vaccinations administered through certain Participating Pharmacies are an exception to this exclusion.
8. Drugs which are repackaged by a company other than the original manufacturer.
9. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
10. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by applicable laws and regulations or for the treatment of certain types of cancer when a particular legend drug has been shown to be effective for the treatment of that specific type of cancer even though that legend drug has not been approved for that type of cancer. The drug must have been shown to be effective for the treatment of that particular cancer according to the Federal Secretary of Health and Human Services.
11. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Policy. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
12. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
13. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper.
14. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
15. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the health care plan, or for which benefits have been exhausted.
16. 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.
17. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
18. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by Blue Cross and Blue Shield.
19. Athletic performance enhancement drugs.

20. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.
21. Some equivalent drugs manufactured under multiple brand names. Blue Cross and Blue Shield may limit benefits to only one of the brand equivalents available.
22. Compound drugs.
23. Drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives.
24. Medications in depot or long acting formulations that are intended for use longer than the covered days supply amount.
25. Any Legend Drug which is not listed on the Drug List unless specifically covered elsewhere in this Policy and/or is required to be covered by applicable law or regulation.

PEDIATRIC VISION CARE BENEFITS

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

DEFINITIONS

In addition to the definitions found in the Definitions Section of this Policy, the following definitions are applicable to your vision care benefits:

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

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

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

Ophthalmologist ..... means a duly licensed ophthalmologist.

Optician ..... means a duly licensed optician.

Optometrist ..... means a duly licensed optometrist.

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

A **"Participating Vision Care Provider"** is a Vision Care Provider which has a written agreement with Blue Cross and Blue Shield.

A **"Non-Participating Vision Care Provider"** is a Vision Care Provider which does not have a written agreement with Blue Cross and Blue Shield.

Vision Materials ..... Corrective Lenses and/or Frames.

ELIGIBILITY

Children who are covered under this Policy, up to age 19, are eligible for coverage under this benefit section. NOTE: Once coverage is lost under this Policy, all benefits cease under this benefit section. Extension of benefits due to disability, state or federal continuation coverage and conversion option privileges are not available under this benefit section.

COVERED SERVICES

Your vision care coverage provides benefits for:

- **Lenses**
- **Frames**
- **Contact Lenses**
- **Low Vision devices**
- **Laser Vision Correction Surgery (Lasik)** —You are entitled to receive a discount for traditional and custom Lasik from participating Physicians and affiliated laser centers. You may call the customer service number on the back of your ID card for information on participating Physicians and affiliated laser centers.

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

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

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

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

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

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

HOW THIS VISION CARE PLAN WORKS

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

Before you go to a Participating Vision Care Provider for an eye examination, eyeglasses or Contact Lenses, please call ahead for an appointment. When you arrive, show the receptionist your identification card. If you forget to take your identification card, be sure to say that you are a member of the Blue Cross and Blue Shield vision care plan so that your eligibility can be verified.

To locate a Participating Vision Care Provider, visit our website at *www.bcbsil.com*, or contact the customer service telephone number on the back of your identification card to obtain a list of the Participating Vision Care Providers nearest you. If you obtain eyeglasses or Contact Lenses from a Non-Participating Vision Care Provider, you must pay the Provider in full and submit a Claim for reimbursement.

You may receive your eye examination and eyeglasses/Contact Lenses on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Provider. Continuity of care will best be maintained when all available services are obtained at one time from one Provider and there may be additional professional charges if you seek Contact Lenses from a Provider other than one who performed your eye examination.

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

Please see your Schedule Page for a complete schedule of pediatric vision care coverage.

LIMITATIONS AND EXCLUSIONS

In addition to the EXCLUSIONS — WHAT IS NOT COVERED section of this Policy, this benefit section does not cover services or supplies connected with or charges arising from:

— Any vision service, treatment or materials not specifically listed as a Vision Care Covered Service on your Schedule Page.

— Services and materials that are experimental or Investigational.

— Services or materials which are prior to your effective date.

— Services and materials incurred after the termination date of your coverage, unless otherwise indicated.

— Services and materials not meeting accepted standards of optometric practice.

— Services and materials resulting from your failure to comply with professionally prescribed treatment.

— Telephone consultations.

— Any charges for failure to keep a scheduled appointment.

— Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.

— Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in illegal occupation, or participating in a riot, rebellion or insurrection.

— Office infection control charges.

— Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts.

— State or territorial taxes on vision services performed.

— Medical treatment of eye disease or injury.

— Visual therapy.

— Special lens designs or coatings other than those described in this benefit section.

— Replacement of lost or stolen eyewear.

— Non-prescription (Plano) Lenses.

— Two pair of eyeglasses in lieu of bifocals.

— Services not performed by licensed personnel.

— Prosthetic devices and services.

— Insurance of Contact Lenses.

— Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

PREADMISSION CERTIFICATION AND CONCURRENT REVIEW

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

PREADMISSION CERTIFICATION

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

CONCURRENT REVIEW

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

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

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EXCLUSIONS — WHAT IS NOT COVERED

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

— Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the EMERGENCY CARE BENEFITS section, SUBSTANCE USE DISORDER TREATMENT BENEFITS section, HOSPITAL BENEFITS section and, for Mental Illness (other than Serious Mental Illness) or routine vision examinations, in the PHYSICIAN BENEFITS section of this Policy.

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

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

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

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

— Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Investigational in nature, except as specifically provided for in this Policy for a) the cost of routine patient care associated with Investigational treatment if you are a qualified individual participating in an Approved Clinical Trial, if those services or supplies would otherwise be covered under this Policy if not provided in connection with an Approved Clinical Trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

— Custodial Care Service.

— Long Term Care Services.

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

— Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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

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

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

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

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

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

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

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

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

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

— Hypnotism.

— Inpatient Private Duty Nursing Service.

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

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

— Maintenance Care.

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

— Residential Treatment Centers, except for Inpatient Chemical Dependency Treatment or Inpatient Mental Illness as specifically mentioned in this Policy.

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

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

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

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

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

— Wigs (also referred to as cranial prostheses).

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

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

— Acupuncture.

— Reversal of vasectomies.

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

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

HOW TO FILE A CLAIM

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

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

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

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

Mail all of that information to:

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

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

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

FILING OUTPATIENT PRESCRIPTION DRUG PROGRAM CLAIMS

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

1. Complete an Outpatient Prescription Drug Program Claim Form. These forms are available from Blue Cross and Blue Shield.
2. Attach copies of all pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

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

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

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

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

If a Claim Is Denied or Not Paid in Full

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

1. The reasons for determination;
2. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;
3. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
4. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.
5. An explanation of 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;
6. In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by 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 on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
10. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
11. In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification; and
12. Contact information for applicable office of health insurance consumer assistance or ombudsman.

INQUIRIES AND COMPLAINTS

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

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

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

- Claims
- Quality of care

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

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

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

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If 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.

Timing of Required Notices and Extensions

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

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

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

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

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:	**72 hours**
after receiving the completed Claim (if the initial Claim is incomplete), within:	**24 hours of receipt of completed Claim**

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

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

Pre-Service Claims

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

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

** This period may be extended one time by Blue Cross and Blue Shield for up to 15 days, provided that Blue Cross and Blue Shield both (1) determines that such an extension is necessary due to matters beyond the control of Blue Cross and Blue Shield and (2) notifies you, prior to the expiration

of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Blue Cross and Blue Shield expects to render a decision.

Post-Service Claims

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

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

Concurrent Care

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

CLAIM APPEAL PROCEDURES

Claim Appeal Procedures - Definitions

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

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

An **"Adverse Determination"** means:

a. a determination by Blue Cross and Blue Shield or its designated 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 it is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

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

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

Expedited Clinical Appeals

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

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

How to Appeal an Adverse Benefit Determination

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

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

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

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

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

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

  Blue Cross and Blue Shield will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with Blue Cross and Blue Shield and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by Blue Cross and Blue Shield.

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 (if the appeal is related to health care services and not related to administrative matters or Complaints) or 30 days after the appeal has been received by Blue Cross and Blue Shield, whichever is sooner.

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

Notice of Appeal Determination

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

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

a. The reasons for the determination;

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

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

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

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

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

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

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

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

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

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

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

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

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

The Illinois Department of Insurance can be contacted at:

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

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

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Blue Cross and Blue Shield Headquarters at 1-800-538-883. Blue Cross and Blue Shield's offices are open from 8:45 a.m. To 4:45 p.m., Monday through Friday.

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

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9432, or call the number on the back of your identification card for contact information.

INDEPENDENT EXTERNAL REVIEW

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

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

1. Standard External Review

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

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

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

For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Blue Cross and Blue 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:

- Standard health care services or treatments have not been effective in improving your condition;
- Standard health care services or treatments are not medically appropriate for you; or
- There is no available standard health care services or treatment covered by Blue Cross and Blue Shield that is more beneficial than the recommended or requested service or treatment.
- In addition, a) your health care provider has certified in writing that the health care service or treatment is likely to be more beneficial to you, in the opinion of your health care provider, than any available standard health care services or treatments; or b) your health care provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.

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

c. Assignment of IRO. When the Director receives notice that your request is eligible for external review following the preliminary review, the Director will, within one business day after the receipt of the notice, a) assign an IRO on a random basis from those IROs approved by the Director; and (b) notify Blue Cross and Blue Shield, you and

your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

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

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

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

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

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

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

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

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

The written notice will include:

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

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

The IRO is not bound by any claim determinations reached prior to the submission of information to the IRO. The Director, you, your authorized representative, if applicable, and Blue Cross and Blue Shield will receive written notice from the IRO.

Standard External Review

Standard External Review	Timing
If you receive an Adverse Determination or a Final Adverse Determination, you may file a 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:	**one 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:	**one business day after the preliminary review**
Blue Cross and Blue Shield shall notify you that a request is eligible for external review within:	**one business day after the preliminary review**
The Director shall assign an independent review organization (IRO) within:	**5 business days**
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)**

2. Expedited External Review

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination; (b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of a Final Adverse Determination of 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 or investigational and your health care provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

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

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

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

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

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

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

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

vices 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 you whether the request is complete and eligible for an expedited external review or is ineligible for review and may be appealed to the Director. The Director may make a determination that the request is eligible for an expedited external review, notwithstanding Blue Cross and Blue Shield's determination.	
The Director 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 Director and you:	**As expeditiously as your medical condition or circumstances require, but no more than 72 hours after the receipt of request.**

External Review of Experimental or Investigational Treatment

Experimental or Investigational Treatment External Review	Timing
You may file a request with the Director for an external review after receipt of an Adverse Determination or a Final Adverse Determination within:	**4 months after date of receipt**
If your treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may make an oral request for an expedited external review, after which the Director shall immediately notify 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 Director shall send a copy of the request to Blue Cross and Blue Shield within:	**one 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 and the Director whether the request is complete and eligible for external review within:	**one business day**
When the Director receives notice that the request is eligible for external review, the Director shall:	
assign an IRO and notify Blue Cross and Blue Shield of the name of the IRO, within:	**one business day**
notify you of the request's eligibility and acceptance for external review and the name of the IRO, within:	**one business day**
If you are notified that your request for an external review has been accepted, you must submit additional information to the assigned IRO within:	**5 business days**
The assigned IRO shall then select one or more clinical reviewers within:	**one business day**
Blue Cross and Blue Shield shall provide to the assigned IRO the documents and any information used in the making the Adverse Determination or Final Adverse Determination within:	**5 business days of notice of assigned IRO**
After being selected by the assigned IRO, each clinical reviewer shall provide an opinion to the assigned IRO on whether the recommended or request health care service shall be covered within:	**20 days**
or, in the case of an expedited external review:	**immediately, but in no event more than 5 calendar days**
The assigned IRO shall make a decision after receipt of the opinion from each clinical reviewer and provide notification of the decision to the Director, you and 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**

OTHER THINGS YOU SHOULD KNOW

THIRD PARTY RECOVERY

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

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

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield has contracts with certain Providers and other suppliers of goods and services for the provision of and/or payment for health care goods and services to all persons entitled to health care benefits under individual and group policies or contracts to which Blue Cross and Blue Shield is a party.

Under certain circumstances described in its contracts with such Providers and suppliers, Blue Cross and Blue Shield may:

- receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which Blue Cross and Blue Shield was obligated to pay the Provider or supplier, or
- pay Providers or suppliers substantially less than their Claim Charges for goods or services, by discount or otherwise, or
- receive from Providers or suppliers other substantial allowances under 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 Policy and the calculation of all required deductible and Coinsurance amounts payable by you under this Policy shall be based on the Provider's Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. You are not 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 Policy.
3. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Provider's Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.
4. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.
5. After taking into account the deductible and Coinsurance amounts, 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. 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 you are not entitled to any part of these savings.

Blue Cross and Blue Shield may receive such payments, discounts, and/or other allowances during the term of the Policy.

You are not entitled to receive any portion of any such payments, discounts, and/or other allowances. Any Copayments and/or deductibles payable by you are pre-determined fixed amounts, based upon the selected benefit plan, which are not impacted by any discounts or contractual allowances which Blue Cross and Blue Shield may receive from a Provider.

OTHER BLUE CROSS AND BLUE SHIELD PLANS' SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

BlueCard

Blue Cross and Blue Shield hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

Under BlueCard, when you receive health care services outside of Illinois and from a Provider which does not have a contract with Blue Cross and Blue Shield, the amount you pay, if not covered by a flat dollar Copayment, for Covered Services is calculated on the lower of:

— The billed charges for your Covered Services, or

— The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield.

To help you understand how this calculation would work, please consider the following example:

1. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the Provider to let him or her know that you are covered by Blue Cross and Blue Shield.
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 Blue Cross and Blue Shield and indicates that the negotiated price for the covered service is $80. Blue Cross and Blue Shield 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 Policy.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this provision or require a surcharge, Blue Cross and Blue Shield would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Out-of-Area Services

Blue Cross and Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans under their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs". Whenever you obtain health care services outside of your Plan's service area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside your Plan's service area and the service area of your Participating IPA/Participating Medical Group, you will obtain care from health care Providers that have a contractual agreement (i.e., are "Participating IPA's/Participating Medical Groups") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Non-Participating Providers. Blue Cross and Blue Shield's payment practices in both instances are described below.

Blue Cross and Blue Shield covers only limited health care services received outside of your Plan's Participating IPA's/ Participating Medical Group's service area. As used in this section, **Other Things You Should Know** "Out- of- Area Covered Services" include emergency care,urgent care and follow- up care obtained outside the geographic area of Blue Cross and Blue Shield's Participating IPA's/Participating Medical Group's service area. Any other services will not be covered when processing through any Inter- Plan Programs arrangements, unless authorized by your Primary Care Physician ("PCP") or Women's Principal Health Care Provider ("WPHCP")

BlueCard® Program

Under BlueCard Program, when you obtain Out- of- Area Covered Services, as defined above, from a health care Provider participating with a Host Blue, Blue Cross and Blue Shield will remain responsible for fulfilling [Blue Cross and Blue Shield] contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

The BlueCard Program enables you to obtain Out- of- Area Covered Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating Provider will automatically file a claim for the Out- of- Area Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Copayment amount, as stated in this Policy.

Emergency Care Services:

If you experience a medical emergency while traveling outside Blue Cross and Blue Shield's the Participating IPA's/Participating Medical Group's service area, go to the nearest emergency facility, urgent care facility, or other health care Provider.

Whenever you access Covered Services outside your Plan's the Participating IPA's/Participating Medical Group's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

— The billed charges for your Covered Services, or

— The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield.

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, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield use[s] for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Blue Cross and Blue Shield would then calculate your liability for any Covered Services according to applicable law.

Non-Participating Healthcare Providers Outside Blue Cross and Blue Shield's Service Area

Liability Calculation

1. In General:

   Except for emergency care and urgent care, services received from a Non-Participating Provider outside of the service area will not be covered.

   For emergency care and urgent care services received from Non-Participating Providers outside of your Participating IPA's/Participating Medical Group's service area, but within Blue Cross and Blue Shield's service area, please refer to the EMERGENCY CARE BENEFITS section of this Policy.

   For emergency care and urgent care services that are provided outside of Blue Cross and Blue Shield's service area by a Non-Participating Provider, the amount(s) you pay for such services will be calculated using the methodology described in the EMERGENCY CARE BENEFITS section for Non-Participating Providers located inside the service area.

2. Exceptions:

   In some exception cases, Blue Cross and Blue Shield may, but is not required to, in its sole and absolute discretion, negotiate a payment with such Non-Participating Provider on an exception basis.

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Plan's Separate Financial Arrangements with Prescription Drug Providers

Blue Cross and Blue Shield hereby informs you that it has contracts, either directly or indirectly, with prescription drug Providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Policy. Under its contracts with Participating Prescription Drug Providers, Blue Cross and Blue Shield may receive from these Providers discounts for prescription drugs dispensed to you. You are not entitled to receive any portion of any such payments, discounts and/or other allowances.

Coinsurance amounts payable by you under this Policy 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:

a. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is $100. How is the $100 paid?

b. You personally will have to pay the Coinsurance amount set out in this Policy.

c. 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.

d. 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.

Plan'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. You are not entitled to receive any portion of such rebates as they are figured into the pricing of the product.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

All benefit payments may be made by Blue Cross and Blue Shield directly to any Provider furnishing the Covered Services for which such payment is due, and Blue Cross and Blue Shield is authorized by you to make such payments directly to such Providers. However, Blue Cross and Blue Shield reserves the right to pay any benefits that are payable under the terms of this Policy directly to you, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by Blue Cross and Blue Shield sufficiently in advance of Blue Cross and Blue Shield's benefit payment. Blue Cross and Blue Shield reserves the right to require submission of a copy of the Assignment of Benefit Payment.

You will not receive any notices regarding Covered Services received from your Primary Care Physician (or other Providers who are part of your Participating IPA/Participating Medical Group) because Claims do not have to be filed for those services.

Once Covered Services are rendered by a Provider, you have no right to request that 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 request.

Except for the assignment of benefit payment described above, neither this Policy nor a covered person's Claim for payment of benefits under this Policy is assignable in whole or in part to any person or entity at any time, and coverage under this Policy is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage.

OUT-OF-POCKET EXPENSE LIMITATION

If, during any calendar year, you have paid Copayments, deductibles and/or any Coinsurance amount for Covered Services under this Policy the total amount of which equals the amount shown on your Schedule Page, your benefits for any additional Covered Services that you may receive during that calendar year, including any Copayment, deductible and/or Coinsurance amounts, will be reimbursed by Blue Cross and Blue Shield. Should the federal government adjust

the deductible and/or out-of-pocket expense limit amount(s) for high deductible health plans, the deductible and/or the out-of-pocket expense limit amount(s) in this Policy will be adjusted accordingly.

In the event your Physician or the Hospital requires you to pay any additional Copayments, deductible and/or Coinsurance amounts after you have met the above provision, upon receipt of properly authenticated documentation, Blue Cross and Blue Shield will reimburse to you, the amount of those Copayments, deductibles and/or Coinsurance amounts.

The above Out-of-Pocket expense limitation provision does not include the following:

- Services, supplies or charges limited or excluded under this Policy; and
- Expenses not covered because a benefit maximum has been reached.

YOUR PROVIDER RELATIONSHIPS

The choice of a Hospital, Participating IPA, Participating Medical Group, Primary Care Physician or any other Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.

Blue Cross and Blue Shield does not itself undertake to provide health care services, but solely to arrange for the provision of health care services and to make payments to Providers for the Covered Services received by you. 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 Hospital or other Provider should not be construed to mean that Blue Cross and Blue Shield is providing professional service.

Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to any Group (other than as an individual Covered Person) or any Group's ERISA Health Benefit Program.

FAILURE OF YOUR PARTICIPATING IPA OR PARTICIPATING MEDICAL GROUP TO PERFORM UNDER ITS CONTRACT

Should your Participating IPA or Participating Medical Group fail to perform under the terms of its contract with Blue Cross and Blue Shield, as determined by Blue Cross and Blue Shield, or fail to renew such contract, the benefits of this Policy will be provided for you for Covered Services received from other Providers limited to Covered Services received during a thirty day period beginning on the date of the Participating IPA's/Participating Medical Group's failure to perform or failure to renew its contract with Blue Cross and Blue Shield. During this thirty day period, you will have the choice of transferring your enrollment to another Participating IPA or Participating Medical Group or of transferring your coverage to any other health care coverage then being offered by your Group to its members. Your transferred enrollment or coverage will be effective thirty-one days from the date your Participating IPA or Participating Medical Group failed to perform or failed to renew its contract with Blue Cross and Blue Shield.

ENTIRE POLICY

This Policy, including any Addenda and/or the Application(s) for the Policy, if any, of the Enrollees constitutes the entire contract of coverage between you and Blue Cross and Blue Shield.

POLICY YEAR

Policy Year means the 12 month period beginning on January 1 of each year.

PREMIUM REBATES, AND PREMIUM ABATEMENTS; ANDCOST-SHARING

a. **Rebate.** In the event federal or state law requires Blue Cross and Blue Shield to rebate a portion of annual premiums paid, Blue Cross and Blue Shield will directly provide any rebate owed participants or former participants to such persons in amounts as required by law.

b. **Abatement.** Blue Cross and Blue Shield may from time to time determine to abate (all or some of) the premium due under this Policy for particular period(s).

Any abatement of premium by Blue Cross and Blue Shield represents a determination by Blue Cross and Blue Shield not to collect premium for the applicable period(s) and does not effect a reduction in the rates under this Policy. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future periods.

c. Blue Cross and Blue Shield makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each participant or former participant (if applicable) owed or provided

a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.

d. **Cost-Sharing.** Blue Cross and Blue Shield reserves the right from time to time to waive or reduce the Coinsurance, Copayments and/or Deductibles under this Policy.

AGENCY RELATIONSHIPS

All information you provide to Blue Cross and Blue Shield will be relied upon as accurate and complete. You must promptly notify Blue Cross and Blue Shield of any changes to such information.

NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield under this Policy must be in writing and sent to Blue Cross and Blue Shield at its offices at 300 East Randolph Street, Chicago, Illinois, 60601-5099 (unless another address has been stated in this Policy for a specific situation). Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield's records and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Policy until at least 60 days have elapsed since a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Policy. In addition, no such action may be brought once 3 years have elapsed from the date that a Claim is required to be furnished to Blue Cross and Blue Shield in accordance with the requirements of this Policy.

VALUE BASED DESIGN PROGRAMS

Blue Cross and Blue Shield has the right to offer a health behavior wellness, maintenance, or improvement programs that allow for a reward, a contribution, a penalty, a differential in premiums or in medical, prescription drug or equipment Copayments, Coinsurance, deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by Blue Cross and Blue Shield or an entity chosen by Blue Cross and Blue Shield to administer such programs. In addition, discount programs for various health and wellness-related or insurance-related items and services may be available from time to time. Such programs may be discontinued without notice. Individuals unable to participate in these incentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, Blue Cross and Blue Shield will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards. Contact Blue Cross and Blue Shield for additional information regarding any value based programs offered by Blue Cross and Blue Shield.

PHYSICAL EXAMINATION AND AUTOPSY

Blue Cross and Blue Shield shall, at its own expense, have the right and opportunity to examine the person of a covered person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Policy, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnification on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield or its agent, and agrees 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, other Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish Blue Cross and Blue Shield information regarding you 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.

QUALIFIED HEALTH PLAN ACTUARIAL VALUE

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a health benefit plan's actuarial value, is not an indicator of the actual amount of expenses that a particular person will be re-

sponsible to pay out of his/her own pocket. A person's out of pocket expenses will vary depending on many factors, such as the particular health care services, health care Providers and particular benefit plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular benefit plan.

MEMBER DATA SHARING

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

DEFINITIONS

Throughout this Policy, many words are used which have a specific meaning when applied to your health care coverage. The definitions of these words are listed below in alphabetical order. **These defined words will always be capitalized when used in this Policy.**

Ambulatory Surgical Facility ……means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services, when operating within the scope of such license.

Approved Clinical Trial ……means a phase I, phase II,phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

1. A federally funded or approved trial,
2. A clinical trial conducted under an FDA investigational new drug application, or
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Autism Spectrum Disorder(s) ……means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including Asperger's disorder and pervasive developmental disorders not otherwise specified.

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

Behavioral Health Practitioner ……means a Physician or professional Provider who is duly licensed to render services for the treatment of Mental Illness, Serious Mental Illness or Substance Use Disorder Treatment.

Certified Clinical Nurse Specialist ……means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and

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

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

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and

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

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

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and

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

Certified Registered Nurse Anesthetist (CRNA) ……means a person who (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists (and is operating within the scope of such license).

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

Chiropractor ……means a duly licensed chiropractor.

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

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

Claim Charge ……means the amount which appears on a Claim as the Provider's or supplier's charge for goods or services furnished to you, without adjustment or reduction and regardless of any separate financial arrangement between the Plan and a particular Provider or supplier. (See provisions of this Policy regarding ''Plan's Separate Financial Arrangements with Providers.'')

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

Clinical Appeal ……means an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that do not meet the definition of an Urgent/Expedited Clinical Appeal.

COBRA ……means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 P.L. 99-272, as amended which regulate the conditions and manner under which an employer can offer continuation of group health insurance to employees and their family members whose coverage would otherwise terminate under the terms of this Policy.

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

Coordinated Home Care Program ……means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.)

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

Continuous Ambulatory Peritoneal Dialysis Treatment ……means a continuous dialysis process using a patient's peritoneal membrane as a dialyzer.

Copayment ……means a specified dollar amount that you are required to pay towards a Covered Service.

Coverage Date ……means the date on which your coverage under this Policy begins.

Covered Service ……means a service or supply specified in this Policy for which benefits will be provided.

Creditable Coverage ……means coverage you had under any of the following:

a) A group health plan.

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

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

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

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

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

g) A State health benefits risk pool.

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

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

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

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

l) Other coverage as required by applicable law.

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

Dentist ……means a duly licensed dentist.

Diagnostic Service ……means tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

Dialysis Facility ……means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

Domestic Partner ……means a person with whom you have entered into a Domestic Partnership.

Domestic Partnership ……means a long-term committed relationship of indefinite duration with a person which meets the following criteria:

a) You and your Domestic Partner have lived together for at least six months;

b) Neither you nor your Domestic Partner is married to anyone else or has another domestic partner;

c) Both you and your Domestic Partner are at least 18 years of age and mentally competent to consent to contract;

d) You and your Domestic Partner reside together and intend to do so indefinitely;

e) You and your Domestic Partner have an exclusive mutual commitment similar to marriage; and

f) You and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

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

Electroconvulsive Therapy ……means a medical procedure in which a brief application of an electric stimulus is used to produce a generalized seizure.

Emergency Condition ……means an accidental bodily injury or a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

b) serious impairment to bodily functions; or

c) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

Emergency Services ……means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

Enrollee ……means the person who has applied for coverage under this Policy and to whom the Plan has issued an identification card.

Enrollment Date ……means the first day of coverage under your health plan or, if you have a waiting period prior to the effective date of your coverage, the first day of the waiting period.

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

As used herein, medical treatment includes medical, surgical, or dental treatment.

"Standard Medical Treatment" means the services or supplies that are in general use in the medical community in the United States, and;

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

b) are appropriate for the Hospital or facility in which they were performed; and

c) the Physician or other professional Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of Blue Cross and Blue Shield shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Physician or professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, Blue Cross and Blue Shield still may determine such services or supplies

to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Family Coverage ……means that your application for coverage was for yourself and other eligible members of your family.

Formulary Drug ……means a brand name prescription drug that has been designated as a preferred drug by the Plan. The listing of drugs designated as being Formulary Drugs may be amended from time to time by the Plan.

Formulary Drug ……means either a brand name prescription drug that has been designated as a preferred drug by the Plan or any generic prescription drug. The listing of drugs designated as being Formulary Drugs may be amended from time to time by the Plan.

Habilitative Services ……means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a treatment plan to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired Disorder.

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

Hospice Care Program Provider ……means an organization duly licensed to provide Hospice Care Program service.

Hospital ……means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

Individual Coverage ……means that your application for coverage was only for yourself.

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

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

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

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy ……means therapy administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Marriage and Family Therapist ……means a duly licensed marriage and family therapist.

Medical Care ……means the ordinary and usual professional services rendered by a Physician, Behavioral Health Practitioner, or other specified Provider during a professional visit, for the treatment of an illness or injury.

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

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

Mental Illness ……means those illnesses classified as mental disorders in the edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association which is current as of the date services are rendered to a patient.

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

(i) Schizophrenia;

(ii) Paranoid and other psychotic disorders;

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

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

(v) Schizoaffective disorders (bipolar or depressive);

(vi) Pervasive developmental disorders;

(vii) Obsessive-compulsive disorders;

(viii) Depression in childhood and adolescence;

(ix) Panic disorder; and

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

(xi) Anorexia nervosa and bulimia nervosa.

Naprapath .....means a duly licensed naprapath.

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

Non-Clinical Appeal .....means an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

Occupational Therapy .....means a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

Ongoing Course of Treatment .....means the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a Physician because of the potential for changes in the therapeutic regimen.

Optometrist .....means a duly licensed optometrist.

Outpatient .....means that you are receiving treatment while not an Inpatient.

Partial Hospitalization Treatment Program .....means a Hospital's planned therapeutic treatment program, which has been approved by your Participating IPA or Participating Medical Group, in which patients with Mental Illness spend days or nights, for less than a 24 hour period.

Participating IPA .....means any duly organized Individual Practice Association of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

Participating Medical Group .....means any duly organized group of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

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

Physical Therapy .....means the treatment by physical means by or under the supervision of a qualified physical therapist.

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

Physician Assistant .....means a duly licensed physician assistant performing under the direct supervision of a Physician.

Plan ……Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association of which Blue Precision HMO is a product line.

Podiatrist ……means a duly licensed podiatrist.

Policy ……means the agreement between Blue Cross and Blue Shield and you, including the Policy, any addenda or riders that apply, the Benefit Program Application and the individual applications, if any, of the persons covered under the Policy.

Prescription Drug Provider ……means any Pharmacy which regularly dispenses drugs.

1. **Participating Prescription Drug Provider** …… means a Prescription Drug Provider which has entered into a written agreement with this Plan, or any entity designated by the Plan to administer its prescription drug program, to provide services to you at the time services are rendered to you and, for Pharmacies located in the state of Illinois, which has direct on-line computer access to the Plan or such administrative entity.
2. **Non-Participating Prescription Drug Provider** …… means a Prescription Drug Provider which does not meet the definition of a Participating Prescription Drug Provider.

Primary Care Physician (PCP) ……means a Provider who is a member or employee of or who is affiliated with or engaged by a Participating IPA or Participating Medical Group and who is a) a Physician who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics, psychiatry or family practice, or b) a Chiropractor, and who you have selected to be primarily responsible for assessing, treating or coordinating your health care needs.

Private Duty Nursing Service ……means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing Service does not include Custodial Care Service.

Provider ……means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) duly licensed to render Covered Services to you.

Provider's Charge ……means a) in the case your Primary Care Physician or another Physician who is affiliated with your Participating IPA/Participating Medical Group, the amount that such Physician would have charged for a good or service had you not been enrolled under this benefit program or b) in the case of a Provider or supplier which is not affiliated with your Participating IPA/Participating Medical Group, such Provider's or supplier's Claim Charge for Covered Services, unless otherwise agreed to by the Plan and the Provider or supplier.

Psychologist ……means:

a) a Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologist Registration Act" (111 Ill. Rev. Stat. §5301 et seq., as amended or substituted); or

b) in a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice; or

c) if practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Substance Use Disorder and who meets the following qualifications:

   1. has a doctoral degree from a regionally accredited University, College or Professional School and has two years of supervised experience in health services of which at least one year is postdoctoral and one year in an organized health services program; or
   2. is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College and has not less than six years experience as a psychologist with at least two years of supervised experience in health services.

Qualified Health Plan or QHP…….means a health care benefit program that has in effect a certification that it meets the applicable government standards.

Qualified Health Plan Issuer or QHP Issuer…….means a health insurance issuer that offers a QHP.

Radiation Therapy ……means the use of ionizing radiation in the treatment of a medical illness or condition.

Rescission……means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums.

Renal Dialysis Treatment ……means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

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

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

Serious Mental Illness ……See definition of Mental Illness.

Skilled Nursing Facility ……means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

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

Specialist Physician ……means a Provider with a contractual relationship or affiliation with the Participating IPA/Participating Medical Group who does not meet the definition of a Primary Care Physician, Woman's Principal Health Care Provider, or Behavioral Health Practitioner.

Speech Therapy ……means treatment for the correction of a speech impairment, including pervasive developmental disorders.

Standing Referral ……means a written referral from your Primary Care Physician or Woman's Principal Health Care Provider for an Ongoing Course of Treatment pursuant to a treatment plan specifying needed services and time frames as determined by your Primary Care Physician or Woman's Principal Health Care Provider, the consulting Physician or Provider and the Plan.

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

Substance Use Disorder Treatment ……means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. It does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court-ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Use Disorder Treatment Facility ……means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and which is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

Surgery ……means the performance of any medically recognized, non-Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Plan.

Tobacco Use Cessation Program……means a program recommended by a Physician that follows evidence-based treatment, such as outlined in the United States Public Health Service guidelines to tobacco use cessation. "Tobacco Use Cessation Program" includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products. "Tobacco Use Cessation Program" includes education and counseling by Physicians or associated medical personnel and all FDA-approved medications for the treatment of tobacco dependence irrespective of whether they are available only over the counter, only by prescription, or both over the counter and by prescription. In addition, Blue Cross and Blue Shield will communicate with you on an annual basis the importance and value of early detection and proactive management of cardiovascular disease.

Tobacco User……means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your identification card or visit our website at *www.bcbsil.com*.

Totally Disabled ……means, with respect to an Eligible Person, an inability by reason of illness or injury to perform his regular or customary occupational duties or, with respect to a covered person other than the Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

Urgent/Expedited Clinical Appeal ……means an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your health.

Woman's Principal Health Care Provider (WPHCP) ……means a physician licensed to practice medicine in all of its branches, specializing in obstetrics or gynecology or specializing in family practice.

IL-I-H-OF-2015
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