

## BENEFIT HIGHLIGHTS

**Plan Name: Blue Options Gold<sup>SM</sup> 001**

**Network Name: Blue Options PPO<sup>SM</sup> Network**

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

THE MEDICAL SERVICES  
ADVISORY PROGRAM

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this Certificate

MSA®

Registered Mark of  
Health Care Service Corporation  
a Mutual Legal Reserve Company

Lifetime Maximum

for all Benefits

Unlimited

Individual Deductible

- Blue Options Provider \$500 per benefit period
- Participating Provider Option \$1,500 per benefit period
- Out-of-Network and Non-Plan Provider \$3,000 per benefit period

Family Deductible

- Blue Options Provider \$1,500 per benefit period
- Participating Provider Option \$4,500 per benefit period
- Out-of-Network and Non-Plan Provider \$9,000 per benefit period

Individual Out-of-Pocket  
Expense Limit

**(does not apply to all services)**

- Blue Options \$4,000 per benefit period
- Participating Option \$6,000 per benefit period
- Out-of-Network \$12,000 per benefit period
- Non-Plan Provider No limit

Family Out-of-Pocket

Expense Limit

**(does not apply to all services)**

- Blue Options \$12,000 per benefit period
- Participating Option \$13,200 per benefit period
- Out-of-Network \$26,400 per benefit period
- Non-Plan Provider No limit

**AFTER CALENDAR YEAR DEDUCTIBLE, UNLESS OTHERWISE SPECIFIED**

**INPATIENT HOSPITAL BENEFITS** – Daily bed, board and general nursing care, ancillary services (i.e., operating rooms, drugs, surgical dressings and lab work)

**OUTPATIENT HOSPITAL BENEFITS** – Includes but is not limited to Surgery, Diagnostic Services, radiation therapy, Chemotherapy, electroconvulsive therapy, Renal Dialysis Treatments and continuous ambulatory peritoneal dialysis treatment, coordinated home care program, pre-admission testing, partial hospitalization treatment program, Autism Spectrum Disorders, Habilitative Services, surgical implants, Maternity Services, and Urgent Care.

**HOSPITAL BENEFITS**

Benefit Level for Covered Services from a:

**Blue Options Provider**

- |                                  |                                   |
|----------------------------------|-----------------------------------|
| — Inpatient Deductible           | You pay \$250 per occurrence      |
| — Inpatient Covered Services     | We pay 90% of the Eligible Charge |
| — Outpatient Surgical Deductible | You pay \$200 per admission       |
| — Outpatient Covered Services    | We pay 90% of the Eligible Charge |

**Participating Provider Option**

- |                                  |                                   |
|----------------------------------|-----------------------------------|
| — Inpatient Deductible           | You pay \$500 per occurrence      |
| — Inpatient Covered Services     | We pay 70% of the Eligible Charge |
| — Outpatient Surgical Deductible | You pay \$400 per occurrence      |
| — Outpatient Covered Services    | We pay 70% of the Eligible Charge |

**Out-of-Network and Non-Plan Provider**

- |                              |                                   |
|------------------------------|-----------------------------------|
| — Inpatient Deductible       | You pay \$600 per admission       |
| — Inpatient Covered Services | We pay 50% of the Eligible Charge |

- Outpatient Surgical                      You pay \$500 per occurrence Deductible
- Outpatient Covered                      We pay 50% of the Eligible Charge  
Services

**INFUSION THERAPY**

We pay 20% less than the Outpatient Hospital Services Benefit Level for covered hospital-based Infusion Therapy services, but never less than 50% of the Eligible Charge.

Hospital Emergency Care

- Benefit Level for covered    We pay 90% of the Eligible Charge  
Emergency Accident  
Care from a:

**Blue Options,  
Participating, Out-of-Network  
or Non-Plan Provider:**

- Emergency Medical                      We pay 90% of the Eligible Charge  
Care from a:

**Blue Options,  
Participating, Out-of-Network  
or Non-Plan Provider:**

Emergency Room                      You pay \$400 Copayment  
(waived if admitted to the Hospital  
as an Inpatient immediately following  
emergency treatment)

Urgent Care

- Benefit Level for                      You pay \$75 Copayment, no  
Urgent Care from a:                      Deductible

**Blue Options,  
Participating, Out-of-Network  
or Non-Plan Provider:**

**PHYSICIAN BENEFITS** – Includes but is not limited to Surgery, Anesthesia Services, assistant surgeon, Medical Care, treatment of Mental Illness, consultations, mammograms, outpatient periodic health examinations, routine pediatric care, Diagnostic Services, injected medicines, amino acid-based elemental formulas, electroconvulsive therapy, radiation therapy, Chemotherapy, cancer medications, outpatient rehabilitative therapy, Autism Spectrum Disorders, Habilitative Services, outpatient respiratory therapy, chiropractic and osteopathic manipulation, hearing screening, diabetes self-management training and education, routine pediatric vision examinations, eyewear and low vision, dental accident care, family planning services,

outpatient contraceptive services, bone mass measurement and osteoporosis, investigational cancer treatment, infertility treatment, pediatric dental services, mastectomy related services, Maternity Services, and Urgent Care.

#### PHYSICIAN BENEFITS

Benefit Level for Surgical/  
Medical Covered Services:

- **Blue Options Provider:** We pay 90% of the Maximum Allowance
- **Participating Provider:** We pay 70% of the Maximum Allowance
- **Out-of-Network Provider:** We pay 50% of the Maximum Allowance

Benefit Level for  
Covered Services received in a  
Professional Provider's Office:

- **Blue Options Provider (other than a specialist):** You pay \$20 per visit, then we pay 100% of the Maximum Allowance
- **Participating Provider (other than a specialist):** You pay \$50 per visit, then we pay 100% of the Maximum Allowance
  
- **Blue Options Provider Specialist:** You pay \$40 per visit, then we pay 100% of the Maximum Allowance
- **Participating Provider Specialist:** You pay \$100 per visit, then we pay 100% of the Maximum Allowance
- **Out-of-Network Provider (other than a specialist):** We pay 50% of the Maximum Allowance
- **Out-of-Network Provider Specialist:** We pay 50% of the Maximum Allowance

Benefit Level for Emergency Accident Care We pay 90% of the Maximum Allowance

Benefit Level for Emergency Medical Care We pay 90% of the Maximum Allowance

**PREVENTIVE CARE SERVICES** – Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, Deductible, Copayment or dollar maximum (to be implemented in the quantities and at the times required by applicable law); 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); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and prevention with respect to the individual involved; evidence-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 additional preventive care and screenings 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).

Benefit level for covered Preventive Services received from a:

- **Blue Options Provider**                      We pay 100% of the Maximum Allowance
- **Participating Provider**                      We pay 100% of the Maximum Allowance
- **Out-of-Network Provider**                      We pay 50% of the Maximum Allowance

**OTHER COVERED SERVICES** – Blood and blood components; medical and surgical dressings, supplies, casts and splints, prosthetic devices, orthotic devices and durable medical equipment.

**OTHER COVERED SERVICES**

Benefit Level

- **Blue Options**                                      We pay 90% of the Eligible Charge or Maximum Allowance
- **Participating Provider**                      We pay 70% of the Eligible Charge or Maximum Allowance

**PEDIATRIC DENTAL CARE SERVICES** – Includes but is not limited to. Diagnostic Evaluations, Diagnostic Radiographs, Miscellaneous Preventive Services, Basic Restorative Dental Services, Non-Surgical Extractions, Non-Surgical Periodontal Services, Adjunctive Services, Endodontic Services, Oral Surgery Services, Surgical Periodontal Services, Major Restorative Services, Miscellaneous Restorative and Prosthodontic Services, Orthodontic Dental Services, Implant Placement Surgery.

**PEDIATRIC DENTAL CARE SERVICES**

Benefit level for Pediatric Dental  
Services received from a:

- **Participating Provider:** We pay 70% of the Maximum Allowance
- **Non- Participating Provider:** We pay 50% of the Maximum Allowance

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

## OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

### Preferred Participating Copayment and/or Coinsurance for covered drugs and supplies

#### Copayment for drugs and supplies

- Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and insulin syringes      You pay \$0 per prescription
- Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes      You pay \$10 per prescription
- Formulary Brand Name Drugs and Formulary brand name diabetic supplies and insulin and insulin syringes      You pay \$35 per prescription
- Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available      You pay \$75 per prescription
- Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available      You pay \$75 per prescription, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription
- Specialty Drugs      You pay \$150 per prescription

**Participating Copayment and/or Coinsurance for covered drugs and supplies**

Copayment for drugs and supplies

- Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and insulin syringes      You pay \$5 per prescription
- Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes      You pay \$15 per prescription
- Formulary Brand Name Drugs and Formulary brand name diabetic supplies and insulin and insulin syringes      You pay \$45 per prescription
- Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available      You pay \$85 per prescription
- Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available      You pay \$85 per prescription, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription
- Specialty Drugs      You pay \$150 per prescription



### Home Delivery Prescription Drug Program

#### Copayment for drugs and supplies

- Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and insulin syringes      You pay \$0 per prescription
- Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes      You pay \$30 per prescription
- Formulary Brand Name Drugs and Formulary brand name diabetic supplies and insulin and insulin syringes      You pay \$105 per prescription
- Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available      You pay \$225 per prescription
- Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available      You pay \$225 per prescription, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription
- Specialty Drugs      You pay \$450 per prescription

**PEDIATRIC VISION COVERAGE PROGRAM BENEFITS**

<b>Vision Care Services</b>	<b>In-network Covered Person Cost or Discount</b> (When a fixed-dollar Copayment is due from the Covered Person, the remainder is payable under this Policy up to the covered charge*)	<b>Out-of-network Allowance</b> (maximum amount payable by plan, not to exceed the retail costs)**
<b>Exam</b> (with dilation as necessary):	No Copayment	Up to \$30, after Deductible
<b>Frames:</b>		
<p>“Collection” frame***            Frames covered by this Certificate are limited to the Pediatric Frame Selection of covered frames. The Pediatric Frame Selection includes a selection of frame sizes (including adult sizes) for children up to age 19. The network provider will show you the selection of frames covered by this Certificate. If you select a frame that is not included in the Pediatric Frame Selection covered under this Policy, you are responsible for the difference in cost between the In network provider reimbursement amount for covered frames from the Pediatric Frame Selection and the retail price of the frame selected. If frames are provided by an out-of-network Provider, benefits are</p>	Up to \$150, after Deductible	Up to \$30, after Deductible

limited to the amount shown above. Any amount 1) paid to the in network provider for the difference in cost of a non-Pediatric Frame Selection frame or 2) that exceeds the Maximum Covered Fee for an out-of-network provider supplied frame will not apply to any applicable Deductible, Coinsurance, or out-of-pocket maximum/out-of-pocket Coinsurance maximum.		
---	--	--

<b>Frequency:</b> Examination, Lenses, or Contact Lenses	Once every 12-month benefit period	
Frame	Once every 12-month benefit period	
<b>Standards Plastic, Glass, or Poly Spectacle Lenses:</b>		
Single Vision	Covered, after Deductible	Up to \$25, after Deductible
Lined Bifocal	Covered, after Deductible	Up to \$35, after Deductible
Lined Trifocal	Covered, after Deductible	Up to \$45, after Deductible
Lenticular	Covered, after Deductible	Up to \$45, after Deductible
Note: All lenses include scratch resistant coating with no additional copayment. There may be an additional charge at Walmart and Sam's Club		

<b>Lens Options (add to lens costs above):</b>		
Ultraviolet Protective Coating	No Copayment	Not covered
Polycarbonate Lenses	No Copayment	
Blended Segment Lenses	\$20 Copayment	
Intermediate vision Lenses	\$30 Copayment	
Standard Progressives	No Copayment	
Premium Progressives (Varilux®, etc.)	\$90 Copayment	
Photochromic Glass Lenses	\$20 Copayment	
Plastic Photosensitive Lenses (Transitions®)	No Copayment	
Polarized Lenses	\$75 Copayment	
Standard Anti-Reflective (AR) Coating	\$35 Copayment	
Premium AR Coating	\$48 Copayment	
Ultra AR Coating	\$60 Copayment	
High Index Lenses	\$55 Copayment	
Progressive Lens Options – Members may receive a discount on additional progressive lens options:		
Select Progressive Lenses	\$70 Copayment	
Ultra Progressive Lenses	\$140 Copayment	
Scratch Protection Plan		
Single Vision Lens	\$20 Copayment	
Multifocal Lens	\$40 Copayment	

<b>Contact Lenses:</b> covered once every calendar year – in lieu of eyeglasses		
Elective	Up to \$150, after Deductible	Up to \$75, after Deductible
Medically Necessary contact lenses – Preauthorization is required (see details below)	Up to \$600, after Deductible	Up to \$225, after Deductible

<p>Contact lenses covered under this Policy are limited to the Pediatric Lens Selection. The Network Provider will inform you of the contact lens selection covered under this Policy. If you select a frame that is not included in the pediatric lens selection covered under this Policy, you are responsible for the difference in cost between the network provider reimbursement amount for covered contact lenses available from the Pediatric Contact Lens Selection and the retail price of the contact lenses selected. Any amount 1) paid to the network provider for the difference in cost of a non-Pediatric Contact Lens Selection contact lens or 2) that exceeds the Maximum Covered Fee for Non-Participating Provider supplied contacts will not apply to any applicable Deductible, Coinsurance, or out-of-pocket maximum/out-of-pocket limit/out-of-pocket coinsurance maximum.</p> <p>Note: Additional benefits over allowance are available from participating providers except Walmart and Sam's Club</p>		
---	--	--

Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.

**Value-added features:**

**Laser vision correction:** You will receive a discount for traditional LASIK and custom LASIK from Participating Physicians and affiliated laser centers. You must obtain Preauthorization for this service in order to receive coverage. Prices/discounts may vary by state and are subject to change without notice. Mail-order contact lens replacement: Lens 1-2-3® Program (visit the Lens 1-2-3 website: [www.lens123.com](http://www.lens123.com)).

**Additional Benefits**

**Medically Necessary contact lenses:** Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating providers will obtain the necessary preauthorization for these services.

**Low Vision:** Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision.

With prior approval from Blue Cross and Blue Shield of Illinois, covered persons who required low-vision services and optical devices are entitled to the following coverage, both In- and Out-of Network:

**Low Vision Evaluation:** One comprehensive evaluation every five years (Out-of-Network Maximum Allowance of \$300). This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.

**Low Vision Aid:** Covered for one device per year such as high-power spectacles, magnifiers and telescopes (Out-of-Network Maximum Allowance of \$600 per device and \$1200 lifetime). These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's vision goals and lifestyle needs.

**Follow-up care:** Four visits in any five-year period (Out-of-Network Maximum Allowance of \$100 per visit).

**Warranty:** Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Please ask your Provider for details of the warranty that is available to you.

\* The "covered charge" is the rate negotiated with network providers for a particular Covered Service.

\*\* THE PLAN PAYS THE LESSER OF THE MAXIMUM ALLOWANCE NOTED OR THE RETAIL COST. RETAIL PRICES VARY BY LOCATION.

**YOU WILL BE RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ELIGIBLE CHARGE OR MAXIMUM ALLOWANCE AND THE BILLED CHARGES, WHEN RECEIVING COVERED SERVICES FROM A NON-PARTICIPATING PROVIDER.**

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

# Your Health Care Benefit Program





A message from

## **BLUE CROSS AND BLUE SHIELD**

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

In this Certificate we refer to our company as “Blue Cross and Blue Shield” and we refer to the company that you work for as the “Group.” The Definitions Section will explain the meaning of many of the terms used in this Certificate. All terms used in this Certificate, when defined in the Definitions Section, begin with a capital letter. Whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

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

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

Sincerely,

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

A handwritten signature in cursive script, appearing to read "M. Smith".

Maurice S. Smith

President

## NOTICE

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

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

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 responsible 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.

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

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

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your Certificate’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Certificate. **YOU CAN EXPECT TO PAY MORE THAN THE APPLICABLE COPAYMENT AND COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill.

Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than applicable Copayments, Coinsurance and Deductible amounts. You may obtain further information about the participating status of providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

NOTICE.....	3
DEFINITIONS SECTION.....	5
ELIGIBILITY.....	25
PREAUTHORIZATION REQUIREMENTS.....	33
BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT.....	39
BENEFIT INFORMATION.....	44
HOSPITAL BENEFIT SECTION.....	46
PHYSICIAN BENEFIT SECTION.....	51
OTHER COVERED SERVICES.....	61
SPECIAL CONDITIONS AND PAYMENTS.....	64
PEDIATRIC VISION COVERAGE.....	75
HOSPICE CARE PROGRAM.....	78
OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION.....	79
EXCLUSIONS—WHAT IS NOT COVERED.....	91
COORDINATION OF BENEFITS SECTION.....	93
CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws).....	97
CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION.....	102
CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS.....	103
CONTINUATION COVERAGE RIGHTS UNDER COBRA.....	104
HOW TO FILE A CLAIM.....	107
PEDIATRIC DENTAL BENEFIT SECTION.....	124
PEDIATRIC DENTAL EXCLUSIONS AND LIMITATIONS.....	131
GENERAL PROVISIONS.....	134
REIMBURSEMENT PROVISION.....	143

## DEFINITIONS SECTION

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Certificate, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER. Hereinafter, we refer to Blue Options Gold PPO<sup>SM</sup>, Blue Options Silver PPO<sup>SM</sup> and Blue Options Bronze PPO<sup>SM</sup> collectively as the benefit program.

**ADVANCED PRACTICE NURSE.....**means a Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist operating within the scope of his or her certification.

**AMBULANCE TRANSPORTATION.....**means local transportation in a specially equipped vehicle for certified ground and air transportation options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

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

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

A “Plan Ambulatory Surgical Facility” means an Ambulatory Surgical Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to participants in the benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

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

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

**APPROVED CLINICAL TRIAL.....**means 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:

- (i) A federally funded or approved trial,
- (ii) A clinical trial conducted under an FDA Experimental/Investigational new drug application, or
- (iii) A drug that is exempt from the requirement of an FDA Experimental/Investigational new drug application.

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

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

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

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorder, and is operating within the scope of such license.

BLUE OPTIONS ...means a network of selected Providers established by Blue Cross and Blue Shield.

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

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

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

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program.

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:

- (iv) 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
- (v) is a graduate of an advanced practice nursing program.

A "Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in the benefit program at the time Covered Services are

rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

A “Out-of-Network Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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.

A “Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Blue Options benefit program at the time services are rendered.

A “Out-of-Network Certified Nurse-Midwife” means a Certified Nurse-Midwife who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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.

A “Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who is classified as having a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services participants in the Blue Options benefit program at the time Covered Services are rendered.

A “Out-of-Network Certified Nurse Practitioner” means a Certified Nurse Practitioner who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who is classified as having a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in the BlueOptions benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

A “Out-of-Network Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

CHIROPRACTOR.....means a duly licensed Chiropractor operating within the scope of his or her license.

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

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

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

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

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

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

A “Out-of-Network Clinical Laboratory” means a Clinical Laboratory which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor operating within the scope of his or her license.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who is classified as having a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services participants in the BlueOptions benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

A “Out-of-Network Clinical Professional Counselor” means a Clinical Professional Counselor who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker operating within the scope of his or her license.

A “Participating Clinical Social Worker” means a Clinical Social Worker who is classified as having a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in the BlueOptions benefit program or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

A “Out-of-Network Clinical Social Worker” means a Clinical Social Worker who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

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

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

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

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

A “Plan Coordinated Home Care Program” means a Coordinated Home Care Program which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in the BlueOptions benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered to you.

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

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

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

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



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

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

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

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

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

A “Plan Dialysis Facility” means a Dialysis Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in the BlueOptions benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

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

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person which meets the following criteria:

- (i) you and your Domestic Partner have lived together for at least 6 months,
- (ii) neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner,
- (iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,
- (iv) your Domestic Partner resides with you and intends to do so indefinitely,
- (v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and
- (vi) you and your Domestic Partner are jointly responsible for each other’s common welfare and share financial obligations.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider when operating within the scope of such license.

A “Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Out-of-Network Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to participants in the BlueOptions benefit program, or is designated as a Participating Provider by any Blue Cross and/or Blue Shield at the time Covered Services are rendered, such Provider’s Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to participants in the BlueOptions benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield plan at the time Covered Services are rendered, will be the lesser of:

- (i) the Provider’s billed charges, or;
- (ii) Blue Cross and Blue Shield of Illinois non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 105% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

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

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

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

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

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (ii) serious impairment to bodily functions; or
- (iii) serious dysfunction of any bodily organ or part.

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

**EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....**means an admission for the treatment of Mental Illness or Substance Use Disorder as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

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

**ENROLLMENT DATE.....**means the first day of coverage under your Group's health plan or, if your Group has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins). No such waiting period may exceed 90 days unless permitted by applicable law. If our records show that your Group has a waiting period that exceeds the time period permitted by applicable law, then we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your Group is responsible for your waiting period. If you have questions about your waiting period, please contact your Group.

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

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

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or other Facility Provider in which the treatment or procedure were performed; and
- the Physician or other Professional Provider has had the appropriate training and experience to provide the treatment or procedure.

Blue Cross and Blue Shield shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and may consider, but will not be bound to follow, 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 Blue Shield of Illinois 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 coverage for you and your eligible spouse and/or dependents under this Certificate.

**GROUP POLICY or POLICY**.....means the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, the Group's Application and the Plan, as appropriate, along with any exhibits, appendices, addenda and/or other required information and the individual Application(s) of the persons covered under the Policy.

**HABILITATIVE SERVICES**....means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a treatment plan to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for a Covered Person with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in the Certificate.

**HOME INFUSION THERAPY PROVIDER**.....means a duly licensed home infusion therapy provider, when operating within the scope of such license.

A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in the BlueOptions benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

A "Out-of-Network Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

**HOSPICE CARE PROGRAM PROVIDER**.....means an organization duly licensed to provide Hospice Care Program Service, when operating within the scope of such license.

A "Participating Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield to provide services to participants in the BlueOptions benefit program, or; (ii) a Hospice Care Program Provider that has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider in the PPO Network listed in the Schedule.

A "Out-of-Network Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield plan to provide services to participants in the BlueOptions benefit program, or; (ii) a Hospice Care Program Provider which has not been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider in BlueOptions benefit program.

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

HOSPITAL.....means a duly licensed institution under state law for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses, irrespective of whether the institution provides surgery on its premises or at another licensed hospital pursuant to a formal written agreement between the two institutions. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

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

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

A “Participating Hospital” means a Plan Hospital that has an agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the BlueOptions benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

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

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

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

INFUSION THERAPY.....means the administration of medication through a needle or catheter. It is prescribed when a patient’s condition is so severe that it cannot be treated effectively by oral medications. Typically, “Infusion Therapy” means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

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

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

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

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of

recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

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

LIFE-THREATENING DISEASE OR CONDITION.....means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

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

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST (“LMFT”).....means a duly licensed marriage and family therapist operating within the scope of his or her license.

A “Participating Marriage and Family Therapist” means a Marriage and Family Therapist who is classified as having a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Out-of-Network Marriage and Family Therapist” means a Marriage and Family Therapist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

MAXIMUM ALLOWANCE.....means (a) the amount which Blue Options or Participating Option Participating Professional Providers have agreed to accept as payment in full, or the amount of reimbursement amount set by the Plan for Providers designated as Participating Professional Providers, for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Out-of-Network Professional Providers, the Maximum Allowance will be the lesser of:

- (i) the Provider’s billed charges, or;
- (ii) Blue Cross and Blue Shield of Illinois non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 105% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

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

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

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

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

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

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

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

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's initial decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so as described in the HOW TO FILE A CLAIM section of this Certificate.

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

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

- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician’s office.
- Continued Inpatient Hospital care, when the patient’s medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. w1395 et seq.).

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. w1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

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

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

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

- (i) Schizophrenia;
- (ii) Paranoid and other psychotic disorders;
- (iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) Major depressive disorders (single episode or recurrent);
- (v) Schizoaffective disorders (bipolar or depressive);
- (vi) Pervasive developmental disorders;
- (vii) Obsessive-compulsive disorders;
- (viii) Depression in childhood and adolescence;
- (ix) Panic disorder;
- (x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- (xi) Anorexia nervosa and bulimia nervosa.

NAPRAPATH.....means a duly licensed Naprapath operating within the scope of his or her license.



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

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

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

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist operating within the scope of his or her license.

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

OPTOMETRIST.....means a duly licensed Optometrist operating within the scope of his or her license.

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

A “Out-of-Network Optometrist” means an Optometrist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OPHTHALMOLOGIST..... means a duly licensed Physician, Ophthalmologist operating within the scope of his or her license.

ORTHOTIC PROVIDER.....means a duly licensed Orthotic provider operating within the scope of his or her license.

A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to you at the time services are rendered.

A “Out-of-Network Orthotic Provider” means an Orthotic Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

OUT-OF-NETWORK HOSPITAL.....SEE DEFINITION OF HOSPITAL.

OUT-OF-NETWORK PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

OUT-OF-NETWORK PROVIDER.....SEE DEFINITION OF PROVIDER.

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

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

PARTICIPATING HOSPITAL..... SEE DEFINITION OF HOSPITAL

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

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

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

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

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

PHYSICAL THERAPIST.....means a duly licensed physical therapist operating within the scope of his or her license.

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

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

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

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

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

PODIATRIST.....means a duly licensed Podiatrist operating within the scope of his or her license.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this Certificate.

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

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

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider operating within the scope of his or her license.

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in the BlueOptions benefit program at the time Covered Services are rendered or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

A “Out-of-Network Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

A “Non-Plan Provider” means a Provider that does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

A “Participating Provider” means a Plan Hospital or Professional Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in a Blue Options or Participating Provider Option program or a Plan facility or Professional Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider.

An “Out-of-Network Provider” means a Plan Hospital or Professional Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in a Participating Provider Option program or a facility which has not been designated by Blue Cross and Blue Shield of Illinois as a Participating Provider.

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

A “Participating Professional Provider” means a Professional Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in a Participating Provider Option program or a Professional Provider who has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Professional Provider.

A “Participating Prescription Drug Provider” means a Pharmacy that has a written agreement with a Blue Cross and/or Blue Shield Plan, or with the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide services to participants in the BlueOptions benefit program at the time Covered Services are rendered, or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered..

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

PSYCHOLOGIST.....means a Registered Clinical Psychologist operating within the scope of his or her license.

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

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

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

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

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

**REGISTERED SURGICAL ASSISTANT.....**means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant, operating within the scope of his or her license.

A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who is classified as having a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A “Out-of-Network Registered Surgical Assistant” means a Registered Surgical Assistant who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

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

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

Requirements: Blue Cross and Blue Shield of Illinois requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by Blue Cross and Blue Shield of Illinois as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

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

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

A “Participating Retail Health Clinic” means a Retail Health Clinic who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A “Out-of-Network Retail Health Clinic” means a Retail Health Clinic who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

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

Routine Patient Costs do not include:

- (i) The investigational item, device, or service, itself;
- (ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- (iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services, and operating within the scope of such license.

A “Plan Skilled Nursing Facility” means a Skilled Nursing Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to participants in the BlueOptions benefit program at the time Covered Services are rendered, or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered.

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

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

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

SMALL EMPLOYER (Employer).....means a person (individual, corporation, partnership, or other legal entity) who employed an average of at least two employees but not more than 50 Eligible Persons on business days during the preceding Calendar Year and who employs at least two employees on the first day of the plan year.

SPEECH THERAPIST.....means a duly licensed Speech Therapist, and operating within the scope of such license.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease including pervasive developmental disorders, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function.

Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

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

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

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

A “Plan Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to participants in the BlueOptions benefit program at the time Covered Services are rendered, or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered to you.

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

**SURGERY.....**means the performance of any medically recognized, non-Experimental/Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by Blue Cross and Blue Shield.

**TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....**means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

**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 Web site at [www.bcbsil.com](http://www.bcbsil.com).

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

**TRANSPLANT LODGING ELIGIBLE EXPENSE...** means the amount of \$50 per person per day

reimbursed for lodging expenses related to a covered transplant.

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

## ELIGIBILITY

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

- Meet the definition of an Eligible Person as specified in the Group Policy;
- Have applied for this coverage;
- Have received a Blue Cross and Blue Shield identification card;
- Live within the service area of Blue Cross and Blue Shield. (Contact your Group or Customer Service for information regarding service area.); and,
- Reside, live or work in the geographic network service area served by Blue Cross and Blue Shield for this Certificate of coverage. You may call Customer Service at the number shown on the back of your identification card to determine if you are in the network service area or log on to the Web site at [www.bcbsil.com](http://www.bcbsil.com).

### Replacement of Discontinued Group Coverage

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

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

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

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

### APPLYING FOR COVERAGE

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

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

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



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

A Tobacco User may be subject to a premium of up to 1.5 times the rate applicable to those who are not Tobacco Users, to the extent permitted by applicable law, provided that Blue Cross and Blue Shield will provide an opportunity to offset such premium variation through participation in a wellness program to prevent or reduce Tobacco Use, if required by applicable law.

You may enroll in or change coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents during one of the following enrollment periods. Your and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' effective date will be determined by the Blue Cross and Blue Shield, depending upon the date your Application is received and other determining factors.

Blue Cross and Blue Shield may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an Eligible Person and/or family member under this Certificate.

#### **Annual Open Enrollment Periods/Effective Date of Coverage**

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

This section "Annual Open 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**

##### **Special Enrollment Periods/Effective Dates of Coverage**

Special Enrollment Periods have been designated during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents. You must apply for or request a change in coverage within 30 days from the date of a special enrollment event, except as otherwise provided below, in order to qualify for the changes described in this Special Enrollment Periods/Effective Dates of Coverage section.

Except as otherwise provided below, if you apply between the 1<sup>st</sup> day and the 15<sup>th</sup> day of the month, your effective date will be no later than the 1<sup>st</sup> day of the following month, or if you apply between the 16<sup>th</sup> day and the end of the month, your and your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' effective date will be no later than the 1<sup>st</sup> day of the second following month.

Special Enrollment Events:

1. You gain or lose a dependent or become a dependent through marriage, becoming a party to a Civil Union or establishment of a Domestic Partnership, provided your employer covers Domestic Partners. New coverage for you and/or your eligible spouse, party to a Civil Union or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective no later than the first day of the following month.

2. You gain or lose a dependent through birth, adoption, or placement of a foster child or for adoption or court-ordered dependent coverage. New coverage for you and/or your eligible spouse, party to a Civil Union or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective on the date of the birth, adoption, or placement of a foster child or for adoption. However, the effective date for court-ordered eligible child coverage will be determined by the provisions of the court order.
3. You lose eligibility for coverage under a Medicaid plan or a state child health plan under title XXI of the Social Security Act. You must request coverage within 60 days of loss of coverage.
4. You become eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or state child health plan. You must request coverage within 60 days of such eligibility.

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

### **Other Special Enrollment Events/Effective Dates of Coverage**

You must apply for or request a change in coverage within 30 days from the date of the below other special enrollment events in order to qualify for the changes described in this Other Special Enrollment Events/Effective Dates of Coverage section.

Except as otherwise provided below, if you apply between the 1st day and the 15th day of the month, your effective date will be no later than the 1st day of the following month, or if you apply between the 16th day and the end of the month, your and your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' effective date will be no later than the 1st day of the second following month.

1. Loss of eligibility as a result of:
  - Legal separation, divorce, or dissolution of a Civil Union or a Domestic Partnership, provided your employer covers Domestic Partners;
  - Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent child under this Certificate);
  - Death of an Employee;
  - Termination of employment, reduction in the number of hours of employment.
2. Loss of coverage through an HMO in the individual market because you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents no longer reside, live, or work in the network service area.
3. Loss of coverage through an HMO, or other arrangement, in the group market because you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents no longer reside, live, or work in the network service area, and no other coverage is available to you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents.
4. You incur a claim that would meet or exceed a lifetime limit on all benefits.
5. Loss of coverage due to a Policy no longer offering benefits to the class of similarly situated individuals that include you.
6. Your employer ceases to contribute towards your or/your dependent's coverage (excluding COBRA continuation coverage).
7. COBRA continuation coverage is exhausted.

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

This section "SPECIAL ENROLLMENT PERIODS" is subject to change by Blue Cross and Blue Shield and/or applicable law, as appropriate.

#### **NOTIFICATION OF ELIGIBILITY CHANGES**

It is the Eligible Person's responsibility to notify Blue Cross and Blue Shield of any change to an Eligible Person's name or address or other changes to eligibility. Such changes may result in coverage/benefit changes for you and your eligible family members. For example, if you move out of Blue Cross and Blue Shield's "network service area". You must reside, or 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 live in the network service area, or log on to the Web site at [www.bcbsil.com](http://www.bcbsil.com).

#### **INDIVIDUAL COVERAGE**

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

#### **FAMILY COVERAGE**

Under Family Coverage, your health care expenses and those of your enrolled spouse, party to a Civil Union, Domestic Partner and your (and/or your spouse, party to a Civil Union, Domestic Partner's) enrolled children who are under the limiting age specified below will be covered.

All of the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise. A Domestic Partner and his/her children who have not attained the limiting age specified below may also be eligible dependents, provided your employer covers Domestic Partners. All of the provisions of this Certificate that pertain to a spouse may also apply to a Domestic Partner unless specifically noted otherwise, provided your employer covers Domestic Partners.

"Child(ren)" used hereafter in this Certificate, means a natural child(ren), a stepchild(ren), foster child(ren), adopted child(ren), a child(ren) of your party to a Civil Union or Domestic Partner (provided your employer covers Domestic Partners), 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) of your child(ren), grandchild(ren), child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. In addition, enrolled unmarried children will be covered up to the age of 30 if they:

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

Coverage will continue under the Certificate for an unmarried eligible dependent who is unable to maintain full-time student status as a result of a medically necessary leave of absence or any other change in enrollment, provided that:

- The dependent is enrolled under the Certificate on the basis of being a student at a postsecondary educational institution; and
- The dependent was covered immediately before the first day of the medically necessary leave of absence or other change in enrollment; and

- The dependent child's treating Physician provides to Blue Cross and Blue Shield a written certification stating that the child is suffering from a serious illness or injury and that the leave of absence or other change in enrollment is medically necessary.

Coverage for such a dependent may be continued under the Certificate until the date that is the earlier of:

- One year after the first day of the medically necessary leave of absence or other change in enrollment; or
- The date on which such coverage would otherwise terminate under the terms of the Certificate.

The first day of the medically necessary leave of absence will be documented as the date indicated by the physician in the written certification on which the medical leave or other enrollment change is to begin.

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

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

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

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

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

Coverage under this Certificate is contingent upon timely receipt by Blue Cross and Blue Shield of necessary information and initial premium.

### **MEDICARE ELIGIBLE COVERED PERSONS**

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

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

In general, Medicare pays secondary to the following:

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

respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status."

If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

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

### **Your MSP Responsibilities**

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

### **YOUR IDENTIFICATION CARD**

You will receive an identification (ID) card from Blue Cross and Blue Shield. Your ID card contains your identification number. 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, contact Customer Service or go to [www.bcbsil.com](http://www.bcbsil.com) and get a temporary card online. Always carry your ID card with you.

### **LATE APPLICANTS**

If you do not apply for Family Coverage or to add dependents within the allotted time, you will have to wait until your Group's annual open enrollment period to do so.

### **TERMINATION OF COVERAGE**

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

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

1. The termination date specified by you, if you provide reasonable notice.
2. When the Blue Cross and Blue Shield does not receive the full amount of the premium payment or other charge or amount on time or when there is a bank draft failure of premiums for you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' coverage and the grace period, if any, has been exhausted.
3. You no longer live, reside or work in Blue Cross and Blue Shield's service area and live, work, or reside in Network Service Area.
4. Your coverage has been rescinded.

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

### **Termination of a Dependent's Coverage**

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

### **WHO IS NOT ELIGIBLE**

The following individuals are not eligible for this coverage:

- Incarcerated individuals, other than incarcerated individuals pending disposition of charges,
- Individuals that do not live, reside or work in the network service area.
- Individuals that do not meet Blue Cross and Blue Shield's eligibility requirements or residency standards, as appropriate.

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

### **Extension of Benefits in Case of Discontinuance of Coverage**

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

### **CONVERSION PRIVILEGE**

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

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

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

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

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

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

## PREAUTHORIZATION REQUIREMENTS

Preauthorization is a requirement that you must obtain authorization from Blue Cross and Blue Shield before you receive certain types of Covered Services designated by Blue Cross and Blue Shield.

Failure to contact Blue Cross and Blue Shield or to comply with the determinations of Blue Cross and Blue Shield will result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles and out-of-pocket limit amounts. Providers may bill you for any reduction in payment resulting from failure to contact Blue Cross and Blue Shield or to comply with the determinations of Blue Cross and Blue Shield. We encourage you to call ahead. The pre-notification toll-free telephone number is on your Blue Cross and Blue Shield identification card. Please read the provisions below very carefully. The provisions of this section do not apply to the treatment of Mental Illness and Substance Use Disorder Rehabilitation Treatment. The provisions for the treatment of Mental Illness and Substance Use Disorder Rehabilitation Treatment are specified in the BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT section of this Certificate.

### INPATIENT SERVICE PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preadmission Review**

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

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

The Hospital and your Physician will be advised, with a follow-up notification letter sent to you, your Physician and the Hospital. Blue Cross and Blue Shield will issue these notification letters promptly or not later than 15 calendar days within receipt of the request. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

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

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

- **Maternity Admission Review**

**Maternity Admission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Certificate, if any.**

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

Even though you are not required to call Blue Cross and Blue Shield prior to your maternity admission, if you call Blue Cross and Blue Shield as soon as you find out you are pregnant, Blue

Cross and Blue Shield will begin to monitor your case. When you contact Blue Cross and Blue Shield, you will be asked to answer a series of questions regarding your pregnancy. Blue Cross and Blue Shield will provide you with educational materials which will be informative for you and which you may want to discuss with your Physician. A letter will be sent to your Physician stating that you contacted Blue Cross and Blue Shield. Blue Cross and Blue Shield will monitor your case and will be available should you have questions about your maternity benefits.

- **Skilled Nursing Facility Preadmission Review**

**Skilled Nursing Facility Preadmission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.**

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

- **Coordinated Home Care Program Preadmission Review**

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

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

- **Private Duty Nursing Service Review**

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

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

- **Home Infusion Therapy Review**

**Home Infusion Therapy Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Policy, if any.**

Whenever home infusion therapy is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call Blue Cross and Blue Shield. This call must be made at least one business days prior to receiving services. When you call Blue Cross and Blue Shield, a case manager may be assigned to you for the duration of your care.

- **Hospice Care Program Service Review**



**Hospice Care Program Service Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Policy, if any.**

Whenever Hospice Care Program Service is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call Blue Cross and Blue Shield. This call must be made at least one business day prior to receiving services. When you call Blue Cross and Blue Shield, a case manager may be assigned to you for the duration of your care.

#### **TRANSFER INPATIENT SERVICE PREAUTHORIZATION REVIEW**

Prior to a Physician recommended admission to a Skilled Nursing Facility, a rehabilitation facility, or a long term acute care facility after transferring from an Inpatient facility where you were receiving acute care, you must, in order to receive maximum benefits under this Policy, call Blue Cross and Blue Shield. This call must be made prior to the scheduling of your admission.

In the event of an emergency admission after transferring from an Inpatient facility where you were receiving acute care, you or someone who calls on your behalf, must, in order to receive maximum benefits under this Policy, notify Blue Cross and Blue Shield no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not receive maximum benefits.

Prior to receiving services for the following Physician recommended service(s) after transferring from an Inpatient facility where you were receiving acute care, you must, in order to receive maximum benefits under this Policy, call Blue Cross and Blue Shield. This call must be made prior to you receiving these services:

- Coordinated Home Care Program
- Home Infusion Therapy
- Partial Hospitalization
- Private Duty Nursing
- Hospice Care Program Service

#### **FAILURE TO NOTIFY FOR INPATIENT SERVICES**

The final decision regarding your course of treatment is solely your responsibility and Blue Cross and Blue Shield will not interfere with your relationship with any Provider. However, Blue Cross and Blue Shield has established preauthorization requirements for the specific purpose of assisting you while you determine the course of treatment which will maximize your benefits provided under this Policy.

Should you fail to notify Blue Cross and Blue Shield as required in the Inpatient Service Preauthorization Review provision of this section for Inpatient Covered Services received from a Participating Provider, you will then be responsible for the first \$1,000 or 50%, whichever is less, of the Hospital or facility charges for an eligible stay or the first \$1,000 or 50%, whichever is less, of the charges for eligible Covered Services in addition to any Deductibles, Copayments and/or Coinsurance applicable to this Policy. For Inpatient Covered Services received from a Non-Participating Provider, you will be responsible for the first \$500 should you fail to notify Blue Cross and Blue Shield in addition to any Deductibles, Copayments and/or Coinsurance applicable to this Policy. This amount shall not be eligible for later consideration as an unreimbursed expense under any benefit section of this Policy nor can it be applied to your out-of-pocket expense limit, if applicable to this Policy.

## **OUTPATIENT SERVICE PREAUTHORIZATION REVIEW**

**Outpatient Service Preauthorization Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Policy, if any.**

Whenever the following Outpatient service(s) received by a Participating Provider is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call Blue Cross and Blue Shield. This call must be made at least 2 business days prior to receiving services:

- Molecular Genetic Testing
- Coordinated Home Care
- Home Hemodialysis
- Home Hospice
- Home Infusion Therapy
- Private Duty Nursing
- Transplant Evaluations

Whenever the following Outpatient service(s) received by a Non-Participating Provider is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call Blue Cross and Blue Shield. This call must be made at least 2 business days prior to receiving services:

- Dialysis
- Elective Surgery

## **FAILURE TO NOTIFY FOR OUTPATIENT SERVICES**

Should you fail to Notify Blue Cross and Blue Shield as required in the Outpatient Service Preauthorization Review provision of this section for Outpatient Covered Services received from a Non-Participating Provider, you will be responsible for the first \$500 should you fail to notify Blue Cross and Blue Shield in addition to any Deductibles, Copayments and/or Coinsurance applicable to this Policy. This amount shall not be eligible for later consideration as an unreimbursed expense under any benefit section of this Policy nor can it be applied to your out-of-pocket expense limit, if applicable to this Policy.

## **CASE MANAGEMENT**

After your case has been evaluated, you may be assigned a case manager. In some cases, if your condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan. If you and your Physician choose the alternative treatment plan, then alternative benefits will be provided as described in this Certificate.

The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Certificate.

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

## **LENGTH OF STAY/SERVICE REVIEW**

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

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

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

#### **MEDICALLY NECESSARY DETERMINATION**

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

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

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

#### **PREAUTHORIZATION PROCEDURE**

When you contact Blue Cross and Blue Shield, you should be prepared to provide the following information:

1. the name of the attending and/or admitting Physician;
2. the name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact Blue Cross and Blue shield:

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

#### **APPEAL PROCEDURE**

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

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision

after claim processing has taken place or upon receipt of the notification letter from Blue Cross and Blue Shield, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield  
Claim Review Section  
P. O. Box 2401  
Chicago, Illinois 60690

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

Additional information about appeals procedures is set forth in the CLAIM APPEAL PROCEDURES provision of the How to File a Claim section of this Certificate.

## **BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT**

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

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit may result in a reduction of benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles and out-of-pocket limit amounts. Providers may bill you for any reduction in payment resulting from failure to contact Blue Cross and Blue Shield or to comply with the determinations of Blue Cross and Blue Shield. We encourage you to call ahead. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

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

### **PREADMISSION REVIEW**

- **Inpatient Hospital Preadmission Review**

**Inpatient Hospital Preadmission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.**

Whenever a nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call the Mental Health Unit. This call must be made at least one business day prior to the scheduling of the Hospital admission and the performance of any preadmission tests.

If the proposed Hospital admission does not meet the criteria for Medically Necessary care, it will be referred to a Physician in the Mental Health Unit. If the Mental Health Unit Physician concurs that the proposed admission does not meet the criteria for Medically Necessary care, some days or the entire hospitalization will be denied.

Your Physician and the Hospital will be advised of the determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The Mental Health Unit will issue these notification letters promptly or no later than 15 calendar days within receipt of the request. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Residential Treatment Center Preadmission Review**

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

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

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

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

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

- **Partial Hospitalization Treatment Program Review**

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

Whenever an admission to a Partial Hospitalization Treatment Program is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call the Mental Health Unit. This call must be made at least one (1) business day prior to the scheduling of the admission.

- **Length of Stay/Service Review**

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

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

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

## **OUTPATIENT SERVICE PREAUTHORIZATION REVIEW**

- **Outpatient Service Preauthorization Review**

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

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

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

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

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

#### **FAILURE TO NOTIFY**

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Provider. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits provided under this Certificate.

Should you fail to notify the Mental Health Unit as required in the Preadmission Review provision of this section for Inpatient Covered Services received from a Participating Provider, you will then be responsible for the first \$1,000 or 50%, whichever is less, of the Hospital or facility charges for an eligible stay or the first \$1,000 or 50%, whichever is less, of the charges for eligible Covered Services in addition to any Deductibles, Copayments and/or Coinsurance applicable to this Policy. For Inpatient Covered Services received from a Non-Participating Provider, you will be responsible for the first \$500 should you fail to notify the Mental Health Unit in addition to any Deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any benefit section of this Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate.

**There is no penalty for failure to preauthorize Outpatient behavioral health services**

#### **MEDICALLY NECESSARY DETERMINATION**

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

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

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

#### **MENTAL HEALTH UNIT PROCEDURE**

When you contact the Mental Health Unit you should be prepared to provide the following information:

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

When you contact the Mental Health Unit :

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. may determine that the admission and or services to be rendered are not Medically Necessary.

#### **APPEAL PROCEDURE**

##### **Expedited Appeal**

If you or your Behavioral Health Practitioner disagree with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit

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

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

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

Additional information about appeals procedures is set forth in the CLAIM APPEAL PROCEDURES section of this Certificate.

##### **INDIVIDUAL BENEFITS MANAGEMENT PROGRAM (“IBMP”)**

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



Alternative benefits will be provided only so long as Blue Cross and Blue Shield determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Certificate. Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of this Certificate.

## BENEFIT INFORMATION

Your employer has chosen Blue Cross and Blue Shield's BlueOptions Participating Provider Option ("PPO") benefit program for the administration of your Hospital and Physician benefits and all other Covered Services that provides you access to independently contracted providers participating in the PPO network shown on the Benefit Highlights (the "Network"). This program of health care benefits designed to provide you with economic incentives for using designated Participating Providers.

As a participant in this Benefit Program, a directory of Providers participating in the Network will be available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at [www.bcbsil.com](http://www.bcbsil.com) for a list of independently contracted Participating Hospitals, Professional Providers, Pharmacies and Dentists. While there may be changes in the directory from time to time, selection of Participating Providers by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Group Administrator annually, or as otherwise required, to allow you to make selection within the network.

However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under this Benefit Program will be greater when you use the services of a Participating Provider.

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

### **YOUR BENEFIT PERIOD**

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

### **YOUR DEDUCTIBLE**

Each benefit period you must satisfy the Deductible amount(s) specified in the Benefit Highlights of this Certificate for Covered Services. In other words, after you have Claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

Each time you are admitted to a Hospital you must satisfy the Inpatient deductible amount (if applicable) specified in the Benefit Highlights of this Certificate. This deductible is in addition to your program deductible.

Each time you receive Covered Services for Outpatient Surgery in a Hospital or Non-Plan Hospital, you must satisfy the Outpatient Surgical deductible amount (if applicable) specified in the Benefit Highlights of this Certificate. This deductible is in addition to your program deductible.

If you have Family Coverage and your family has satisfied the family deductible amount specified in the Benefit Highlights of this Certificate, it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the program deductible before receiving benefits.

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

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

When your Group initially purchased this coverage, if you were a member of the Group at that time you are entitled to a special credit toward your Participating Provider program deductible for the first benefit period. This special credit applies to eligible expenses incurred for Covered Services within the prior contract's benefit period, if not completed. Such expenses can be applied toward the Participating Provider program Deductible for the first benefit period under this coverage. However, this is only true if your Group had "major medical" type coverage immediately prior to purchasing this coverage.

## HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your Certificate tells you what Hospital services are covered and how much will be paid for each of these services.

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

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

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

### **INPATIENT CARE**

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

#### **Inpatient Covered Services**

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

#### **Preadmission Testing**

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

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

#### **Partial Hospitalization Treatment Program**

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

#### **Benefits for Routine Patient Costs for Participants in Approved Clinical Trials**

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

#### **Coordinated Home Care Program**

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

## **BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES**

### **After you have met your program Deductible, benefits will be provided as described below. Blue Options**

When you receive Inpatient Covered Services from a Blue Options Provider or in a Plan Program of a Blue Options Option Provider, benefits will be provided at the Blue Options Provider Inpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and your Inpatient Hospital admission deductible, unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

### **If a private room is Medically Necessary, benefits will be based on the Hospital's private room and board rate.**

#### **Participating Provider**

When you receive Inpatient Covered Services from a Participating Provider or in a Plan Program of a Participating Provider, benefits will be provided at the Participating Provider Inpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and your Inpatient Hospital admission deductible, unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

### **If a private room is Medically Necessary, benefits will be based on the Hospital's private room and board rate.**

#### **Out-of-Network Provider**

When you receive Inpatient Covered Services from a Out-of-Network Provider or in a Plan Program of a Out-of-Network Provider, benefits will be provided at the Out-of-Network Provider Inpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and your Inpatient Hospital admission deductible, unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

### **If a private room is Medically Necessary, benefits will be based on the Hospital's private room and board rate.**

#### **Non-Plan Provider**

When you receive Inpatient Covered Services from a Non-Plan Provider, benefits will be provided at the Non-Plan Provider payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and your Inpatient Hospital admission deductible.

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

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

being serious and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

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

**If a private room is medically necessary, benefits will be based on the Hospital's private room and board rate.**

## **OUTPATIENT HOSPITAL CARE**

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

### **Outpatient Hospital Covered Services**

1. **Surgery** and any related Diagnostic Service received on the same day as the Surgery  
In addition to Surgery in a Hospital, benefits will be provided for Outpatient Surgery performed in an Ambulatory Surgical Facility.
2. **Radiation Therapy Treatments**
3. **Chemotherapy**
4. **Electroconvulsive Therapy**
5. **Renal Dialysis Treatments**—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. **Diagnostic Service**—when you are an Outpatient and these services are related to Surgery or Medical Care
7. **Urgent Care**
8. **Emergency Accident Care**
9. **Emergency Medical Care**
10. **Mammograms**—Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.
11. **Pap Smear Test**—Benefits will be provided for an annual routine cervical smear or Pap smear test for females. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
12. **Prostate Test and Digital Rectal Examination**—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
13. **Ovarian Cancer Screening**—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
14. **Colorectal Cancer Screening**—Benefits will be provided for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies

or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

15. **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 at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
16. **Benefits for Routine Patient Costs for Participants in Approved Clinical Trials**—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

## **BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES**

### **Blue Options**

Benefits will be provided at the Blue Options Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program Deductible and any applicable Outpatient Surgery Deductible when you receive Outpatient Hospital Covered Services from a Participating Provider, unless otherwise specified in this Certificate.

### **Participating Provider**

Benefits will be provided at the Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and any applicable Outpatient Surgery Deductible when you receive Outpatient Hospital Covered Services from a Participating Provider, unless otherwise specified in this Certificate.

### **Out-of-Network Provider**

When you receive Outpatient Hospital Covered Services from a Out-of-Network Provider, benefits will be provided at the Out-of-Network Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program Deductible and any applicable Outpatient Surgery deductible, unless otherwise specified in this Certificate.

### **Non-Plan Provider**

When you receive Outpatient Hospital Covered Services from a Non-Plan Provider, benefits will be provided at the Non-Plan Provider payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and any applicable Outpatient Surgery Deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Plan Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Provider.

### **Emergency Care**

Benefits for Emergency Accident Care will be provided at the Emergency Accident Care payment level specified in the Benefit Highlights of this Certificate when you receive Covered Services from either a Blue Options, Participating, Out-of-Network or Non-Plan Provider.

Benefits for Emergency Accident Care will be subject to the program Deductible.

Benefits for Emergency Medical Care will be provided at the Emergency Medical Care payment level specified in the Benefit Highlights of this Certificate when you receive Covered Services from either a Blue Options, Participating, Out-of-Network or Non-Plan Provider.

Benefits for Emergency Medical Care will be subject to the program Deductible.

Each time you receive Covered Services in an emergency room, you may be responsible for an emergency room per occurrence deductible (if applicable) specified in the Benefit Highlights in this Certificate. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room per occurrence deductible will be waived.

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

#### **Urgent Care**

Each time you receive Covered Services in an urgent care facility, you will be responsible for an urgent care facility Copayment amount specified in the Benefit Highlights in this Certificate. Any additional Covered Services received in the urgent care facility will be provided at the payment level for outpatient hospital Covered Services. .

**These Copayment or deductible amounts are subject to change or increase as permitted by applicable law.**

#### **WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)**

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



## PHYSICIAN BENEFIT SECTION

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

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

For benefits to be available, under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

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

### COVERED SERVICES

#### Surgery

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

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

The following services are also part of your surgical benefits:

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

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

2. **Assist at Surgery**—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. **Sterilization Procedures** (even if they are elective)

### **Additional Surgical Opinion**

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

### **Medical Care**

Benefits are available for Medical Care visits when:

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

### **Consultations**

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

### **Diabetes Self-Management Training and Education**

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management, operating within the scope of his or her license or certification. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

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

### **Allergy Injections and Allergy Testing**

#### **Chemotherapy**

#### **Occupational Therapy**

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

#### **Physical Therapy**

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

## **Radiation Therapy Treatments**

### **Electroconvulsive Therapy**

#### **Speech Therapy**

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

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

**Breast Cancer Pain Medication and Therapy** — Benefits will be provided for all Medically Necessary pain medication and therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically based and includes reasonably defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Benefits will also be provided for all Medically Necessary pain medication related to the treatment of breast cancer under the Prescription Drug section of this policy.

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

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

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

**Pap Smear Test**—Benefits will be provided for an annual routine cervical smear or Pap smear test for females. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

**Human Papillomavirus Vaccine**—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. If you purchase the vaccine at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate.

**Shingles Vaccine**—Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration.

**Prostate Test and Digital Rectal Examination**—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

**Ovarian Cancer Screening**—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Unless

otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

**Colorectal Cancer Screening**—Benefits will be provided for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

**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 at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

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

#### **Emergency Accident Care**

#### **Emergency Medical Care**

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

**Durable Medical Equipment**—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

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

**Prosthetic Appliances**

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

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

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

**Orthotic Devices**

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. Your benefits for foot orthotics will be limited to two foot orthotic devices or one pair of foot orthotic devices per benefit period.

**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 at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

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

**Routine Pediatric Hearing Examination**—Benefits will be provided for routine hearing examinations for children up to age 19.

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

**Massage Therapy****Tobacco Use Screening and Smoking Cessation Counseling Services****Tobacco Cessation Drugs****Growth Hormone Therapy****Breast Implant Removal**

**HIV Screening and Counseling** —Benefits will be provided HIV Screening and Counseling and prenatal HIV testing ordered by an Physician, Physician Assistant or Advanced Practice Registered Nurse who has a

written collaborative agreement with a collaborating physician that authorizes these services, including but not limited to orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

### **Fibrocystic Breast Condition**

#### **BENEFIT PAYMENT FOR PHYSICIAN SERVICES**

The benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Blue Options, Participating or Out-of-Network Professional Provider.

#### **Blue Options Provider**

When you receive any of the Covered Services described in this Physician Benefit Section from a Blue Options Provider or from a Dentist, benefits will be provided at the Blue Options Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights of this Certificate after you have met your program deductible, unless otherwise specified in this Certificate. Dentists are not Participating Providers, but will be treated as such for purposes of benefit payment made under this Certificate and may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

When you receive Covered Services (except for those services specified below) in a Blue Options Provider's office (other than a specialist's office), benefits for Covered Services, including all related Covered Services received on the same day, will be provided at the Physician's office payment level specified in the Benefit Highlights of this Certificate.

When you receive Covered Services (except for those services specified below) in a Blue Options Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the same day, will be provided at the specialist's office payment level specified in the Benefit Highlights of this Certificate.

When you receive Covered Services for Diagnostic Services or certain Diagnostic tests (CT scan, PET scan, or MRI) you may be responsible for a per procedure deductible amount in addition to your program deductible specified on the Benefit Highlights of this Certificate.

Benefits for certain Diagnostic tests may require a Copayment amount specified in the Benefit Highlights section of this Certificate. Your program deductible will not apply.

#### **Participating Provider**

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at the Participating Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights of this Certificate after you have met your program deductible, unless otherwise specified in this Certificate. Dentists are not Participating Providers, but will be treated as such for purposes of benefit payment made under this Certificate and may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

When you receive Covered Services (except for those services specified below) in a Participating Provider's office (other than a specialist's office), benefits for Covered Services, including all related Covered Services received on the same day, will be provided at the Physician's office payment level specified in the Benefit Highlights of this Certificate.

When you receive Covered Services (except for those services specified below) in a Participating Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the

same day, will be provided at the specialist's office payment level specified in the Benefit Highlights of this Certificate.

When you receive Covered Services for Diagnostic Services or certain Diagnostic tests (CT scan, PET scan, or MRI) you may be responsible for a per procedure deductible amount in addition to your program deductible specified on the Benefit Highlights of this Certificate.

Benefits for certain Diagnostic tests may require a Copayment amount specified in the Benefit Highlights section of this Certificate. Your program deductible will not apply.

**This Copayment amount is subject to change or increase as permitted by applicable law.**

A specialist is a Provider who is **not** a:

- S Behavioral Health Practitioner
- S Certified Nurse-Midwife
- S Certified Nurse Practitioner
- S Certified Clinical Nurse Specialist
- S Clinical Professional Counselor
- S Clinical Social Worker
- S Clinical Laboratory
- S Marriage and Family Therapist
- S Mixed psychiatric group
- S Mixed specialty group
- S Neuro Psychologist
- S Optician
- S Optometrist
- S Retail Health Clinic

or a Physician in:

- S clinical psychology
- S family practice
- S general practice
- S gynecology
- S internal medicine
- S obstetrics
- S obstetrics/gynecology
- S pediatrics
- S psychiatry

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

- S Surgery

- S Occupational Therapy
- S Physical Therapy
- S Speech Therapy
- S Chiropractic and osteopathic manipulation
- S Diagnostic Services
- S CT scan, PET scan and MRI

**Out-of-Network Provider**

When you receive any of the Covered Services described in this Physician Benefit Section from a Out-of-Network Provider, benefits will be provided at the Out-of-Network Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights of this Certificate after you have met your program deductible.

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

**Emergency Care**

Benefits for Emergency Accident Care will be provided at the Emergency Accident Care payment level specified in the Benefit Highlights of this Certificate when rendered by either a Blue Options, Participating or Out-of-Network Provider. Your program deductible will apply.

Benefits for Emergency Medical Care will be provided at the Emergency Medical Care payment level specified in the Benefit Highlights of this Certificate when rendered by either a Blue Options, Participating or Out-of-Network Provider. Your program deductible will apply.

However, Covered Services for Emergency Medical Care Covered Services for the examination and testing of a victim of a criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection resulting from a criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible. The office visit Copayment will not apply.

**This Copayment amount is subject to change or increase as permitted by applicable law.**

**Participating Providers are:**

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



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

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

**Out-of-Network Providers are:**

- Audiologists
- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists

- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

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

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

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

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

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

## OTHER COVERED SERVICES

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

- The processing, transporting, storing, handling and administration of blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of 15 visits per benefit period.
- Hearing Aids—Benefits will be provided bone anchored hearing aids.
- Hearing Aids—Benefits will be provided for hearing aids for children up to age 19 limited to two every 36 months.

### BENEFIT PAYMENT FOR OTHER COVERED SERVICES

**Benefits will be provided at the Other Covered Services payment level specified in the Benefit Highlights of this Certificate of the Blue Options or Participating Provider amount set by the plan, regardless of whether the Provider is a Blue Options, Participating Provider or Out-of-Network Provider with the Plan, after you have met your program deductible for any of the Covered Services described in this section.**

**Notwithstanding anything else described herein, Providers of Ambulance Services will be paid based on the Ambulance Transportation Eligible Charge. Benefits will be paid at the level specified in the Benefit Highlights of of this Certificate. this benefit plan. You may be responsible for any charges in excess of this amount.** When receiving benefits for Ambulance Transportation related to Emergency Accident Care or Emergency Medical Care, you will not be responsible for amounts other than those listed on the Benefit Highlights of this Certificate.

When you receive Other Covered Services from a Blue Options, Participating or Out-of-Network Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

Participating Providers are:

- Audiologists
- Physicians
- Podiatrists

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

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

**Out-of-Network Providers are:**

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

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

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

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

## SPECIAL CONDITIONS AND PAYMENTS

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

### HUMAN ORGAN TRANSPLANTS

Your benefits for certain Medically Necessary human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants:

- If both the donor and recipient have Blue Cross and Blue Shield coverage each will have their benefits paid by their own Blue Cross and Blue Shield program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

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

- **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact Blue Cross and Blue Shield by telephone before your transplant Surgery has been scheduled. Blue Cross and Blue Shield will furnish you with the names of Hospitals which have Blue Cross and Blue Shield approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Blue Cross and Blue Shield approved Human Organ Transplant Coverage Program.**
- Your benefits under this coverage will begin no earlier than 5 days prior to the transplant Surgery and shall continue for a period of no longer than 365 days after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.
- Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada
- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Certificate, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
  - Benefits for transportation and lodging are limited to a combined maximum of \$10,000 per transplant. The maximum amount that will be provided for lodging is \$50 per person per day.

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

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

### **CARDIAC REHABILITATION SERVICES**

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits 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 transmural myocardial revascularization.

### **Preventive Care Services**

In addition to the benefits otherwise provided for in this Certificate, (and notwithstanding anything in your Certificate to the contrary), the following benefits for preventive care services will be considered Covered Services and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service:

- 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”);
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- 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
- with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this preventive care services benefit provision, 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 above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at [www.bcbsil.com](http://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 or Coinsurance for the office visit only. If an office

visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment or Coinsurance for the office visit including the preventive health service.

**Preventive Care Services for Adults:**

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 infection screening of 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 chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
6. Cervical cancer screening for sexually active women
7. Chlamydia infection screening for younger women and women at higher risk
8. Contraception: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling
9. Domestic and interpersonal violence screening and counseling for all women
10. Folic acid supplements for women who may become pregnant
11. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes



12. Gonorrhea screening for all women at higher risk
13. Hepatitis B screening for pregnant women at their first prenatal visit
14. HIV screening and counseling for sexually active women and Prenatal HIV Testing
15. 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
16. Osteoporosis screening for women over age 60, depending on risk factors
17. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
18. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
19. Sexually transmitted infections (STI) counseling for sexually active women
20. Syphilis screening for all pregnant women or other women at increased risk
21. Well woman visits to obtain recommended preventive services
22. Annual breast cancer mammography screenings for women over 40.
23. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal

**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
  - Human papillomavirus
  - Influenza (Flu shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
  - Haemophilus influenzae type b
  - Rotavirus
  - Inactivated Poliovirus
  - any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.
17. Iron supplements for children ages 6 to 12 months at risk for anemia

18. Lead screening for children at risk for exposure
19. Medical history for all children throughout development
20. Obesity screening and counseling
21. Oral health risk assessment for younger children up to ten years old
22. Phenylketonuria (PKU) screening for newborns
23. Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk
24. Tuberculin testing for children at higher risk of tuberculosis
25. Vision screening for all children
26. Autism screening.
27. Hepatitis C virus (HCV) screening for persons at high risk for infection

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 website at [www.bcbsil.com](http://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 Certificate, subject to any applicable Coinsurance, Copayments, Deductibles and/or benefit maximum. 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 this Certificate, if applicable.

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

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

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

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

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

#### **SKILLED NURSING FACILITY CARE**

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

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

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care. Benefits for Covered Services rendered in a Plan Skilled Nursing Facility will be provided at the Blue Options or Participating Provider Inpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Plan Skilled Nursing Facility will be provided at the Non-Plan Provider payment level specified in the Benefit Highlights of this Certificate, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

#### **AMBULATORY SURGICAL FACILITY**

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

Benefits for services rendered by a Plan Ambulatory Surgical Facility will be provided at the Blue Options or Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate. Benefits for services by a Non-Plan Ambulatory Surgical Facility will be provided at the Non-Plan Provider payment level specified in the Benefit Highlights of this Certificate.

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

#### **SUBSTANCE USE DISORDER REHABILITATION TREATMENT**

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

#### **DETOXIFICATION**

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

#### **MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES**

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

## **BARIATRIC SURGERY**

Benefits for Covered Services received for Bariatric Surgery will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this Certificate, the same as for any other condition.

## **AUTISM SPECTRUM DISORDER(S)**

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

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

## **HABILITATIVE SERVICES**

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

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

## **MATERNITY SERVICE**

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

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. (If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, benefits will be available for that care from the moment of birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage. You may apply for Family Coverage within 31 days of the date of the birth. Your Family Coverage will then be effective from the date of the birth.)

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

may only be provided if there is coverage 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.

### **INFERTILITY TREATMENT**

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of Infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

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

Benefits for treatments that include oocyte retrievals will be provided only when you have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless. Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per benefit period.

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

Following the fourth completed oocyte retrieval in a benefit period, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you.

### **Special Limitations**

Benefits will not be provided for the following:

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

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

### **TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS**

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

### **ROUTINE MAMMOGRAMS**

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

- one baseline mammogram
- an annual mammogram

Benefits for routine mammograms will be provided for women who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at least every year for women ages 40 and over or at the age and intervals considered Medically Necessary by their Physician.

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

#### **Blue Options Provider**

Benefits for routine mammograms will not be subject to any Deductible, Coinsurance or Copayment when such services are received from a Blue Options Provider.

#### **Participating Provider**

Benefits for routine mammograms will not be subject to any Deductible, Coinsurance or Copayment when such services are received from a Participating Provider.

#### **Out-of-Network Provider**

Benefits for routine mammograms when rendered by a Out-of-Network Provider will be provided at the Out-of-Network Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate.

#### **Benefit Maximum**

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

### **MASTECTOMY-RELATED SERVICES**

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

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific

evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge; and

4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

## **PAYMENT PROVISIONS**

### **Lifetime Maximum**

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

### **Cumulative Benefit Maximums**

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

## **OUT-OF-POCKET EXPENSE LIMIT**

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Blue Options Providers, Participating Providers and Out-of-Network Providers.

### **For Blue Options Providers**

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights of this Certificate, any additional eligible Claims for Blue Options Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Out-of-Network or Non-Plan Providers other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

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

- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit

If you have Family Coverage, each member of your family must satisfy the out-of-pocket expense limit.

### **For Participating Providers**

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights of this Certificate, any additional eligible Claims for Participating Providers (except for those Covered Services specifically

excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Out-of-Network or Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

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

- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit

If you have Family Coverage, each member of your family must satisfy the out-of-pocket expense limit.

#### **For Out-of-Network Providers**

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

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

- the payments for Covered Services rendered by a Out-of-Network Provider or Non-Plan Provider for which you are responsible after benefits have been provided

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

- the Coinsurance resulting from Covered Services you may receive from a Participating Provider
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit

If you have Family Coverage, each member of your family must satisfy the out-of-pocket expense limit.

**This out-of-pocket expense limit amount is subject to change or increase as permitted by applicable law.**

#### **EXTENSION OF BENEFITS IN CASE OF TERMINATION**

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



## Pediatric Vision Coverage

Coverage for *Pediatric Vision Care* is made part of, and is in addition to any information you may have in your Blue Cross and Blue Shield of Illinois Certificate. Coverage for *Pediatric Vision Care* provides information about coverage for the routine vision care services outlined below, which are specifically excluded under your medical/surgical health care plan. **(Services that are covered under your medical/surgical Certificate are not covered under this *Pediatric Vision Care* benefit.) All provisions in the medical Certificate apply to coverage for *Pediatric Vision Care* unless specifically indicated otherwise below.**

Your benefits for Pediatric Vision Care are administered by Blue Cross and Blue Shield of Illinois (BCBSIL). BCBSIL has partnered with Davis Vision®, Inc. Davis Vision provides customer service and claims administration services for Pediatric Vision Care. The relationship between BCBSIL and Davis Vision is that of independent contractors. Through our arrangement with Davis Vision, you will have access to Davis Vision's extensive network of vision care Providers.

This BCBSIL vision care plan allows members to select the provider of their choice, Participating or Non-Participating. If you choose an Out-of-Network and/ or Non-Participating Provider benefits will be reduced with a reduction in benefits.

### Definitions

**Benefit Period** – For purposes of this *Pediatric Vision Care* section, a period of time that begins on the later of:

- 1) the member's effective date of coverage, 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. (A benefit period does not coincide with a calendar year and may differ for each covered member of a group or family.)

**Pediatric Frame Collection** – A collection of frames that are covered under the Pediatric Vision Care benefit which includes adult sizes for members up to age 19.

**Provider** – For purposes of *Pediatric Vision Care*, a licensed Ophthalmologist or Optometrist operating within the scope of his or her license, or a dispensing optician.

**Vision Materials** – Corrective lenses and/or frames or contact lenses.

### Eligibility

Children who are covered under a BCBSIL medical/surgical plan, up to age 19, are eligible for coverage for *Pediatric Vision Care*. NOTE: Once coverage is lost under the medical/surgical plan, all benefits cease for *Pediatric Vision Care*. Extension of benefits due to disability, state or federal continuation coverage, and conversion option privileges are **not** available for *Pediatric Vision Care*.

## Limitations and Exclusions

In addition to the general limitations and exclusions listed in your medical/surgical certificate, *Pediatric Vision Care* does not cover services or materials connected with or charges arising from:

- Services provided by non-participating providers for Standard Option members;
- Any vision service, treatment or materials not specifically listed as a Covered Service;
- Services and materials that are Experimental or Investigational;
- Services or materials which are rendered 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;
- 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 brochure;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs 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.

## How the 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 network Provider.

Before you go to a network vision care plan 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 card, be sure to say that you are a member of the BCBSIL vision care plan so that your eligibility can be verified.

To locate a network vision care provider, visit our website at [www.bcbsil.com](http://www.bcbsil.com), or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card to obtain a list of the network vision care plan providers nearest you.

If you obtain glasses or contacts from an out-of-network provider, you must pay the provider in full and submit a claim for reimbursement (see **CLAIM FILING PROCEDURES** for more information).

You may receive your eye examination and eyeglasses/contacts 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 network Provider and there may be additional professional charges if you seek contact lenses from a provider other than the 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 for *Pediatric Vision Care*, must be paid in full by you to the provider, whether or not the provider participates in the vision care plan network. Benefits for *Pediatric Vision Care* may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

## HOSPICE CARE PROGRAM

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

The following services are covered under the Hospice Care Program:

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

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

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

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

### **Benefit Payment for Hospice Care Program Services**

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

## **OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION**

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

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

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

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

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

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

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

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

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

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

- (i) Which is Medically Necessary and is ordered by a Health Care Practitioner naming you as the recipient;
- (ii) For which a written or verbal Prescription Order is provided by a Health Care Practitioner;
- (iii) For which a separate charge is customarily made;
- (iv) Which is not entirely consumed or administered at the time and place that the Prescription Order is written;
- (v) For which the FDA has given approval for at least one indication; and
- (vi) Which is dispensed by a Pharmacy and is received by you while covered under this Benefit Section, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the EXCLUSIONS provision later in this Benefit Section).

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

- (i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or
- (ii) the agreed upon cost between a Participating Pharmacy and a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, whichever is lower.

FORMULARY BRAND NAME DRUG.....means a brand name prescription drug product that is identified on the *Drug List* as a Formulary Brand Name Drug and is subject to the Formulary Brand Name Drug payment level. The *Drug List* is available by accessing the Web site at [www.bcbsil.com](http://www.bcbsil.com).

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

HEALTH CARE PRACTITIONER.....means an Advanced Practice Nurse, doctor of medicine, doctor of dentistry, Physician Assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority acting within the scope of his or her license.

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. The *Drug List* is available by accessing the Web site at [www.bcbsil.com](http://www.bcbsil.com).

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

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

PREFERRED PARTICIPATING PHARMACY..... means a Participating Pharmacy which has a written agreement with Blue Cross and Blue Shield to provide pharmaceutical services to you or an entity chosen by Blue Cross and Blue Shield to administer its prescription drug program that has been designated as a Preferred Pharmacy.

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

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

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

## **ABOUT YOUR BENEFITS**

### ***Drug List***

The benefit payments of 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 **Formulary 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](http://www.bcbsil.com) or calling the Customer Service toll-free number on your identification card, you will be able to determine the **Formulary Drug List** that applies to you and whether a particular drug is on the **Formulary Drug List**. Drugs that appear on the *Drug List* as Non-Formulary Brand Name Drugs are subject to the Non-Formulary Brand Name Drug payment level specified in the Benefit Highlights of this Certificate plus any pricing differences that may apply to the Covered Drug you receive.

You, your prescribing health care provider, or your authorized representative, can ask for a Drug List exception if your drug is not on (or is being removed from) the Drug List (also known as a formulary), or the drug required as part of step therapy or dispensing limits has been found to be (or likely to be) not right for you or does not work as well in treating your condition. To request this exception, you, your prescriber, or your authorized representative, can call the number on the back of your ID card to ask for a review. BCBSIL will let you, your prescriber (or authorized representative) know the coverage decision within 72 hours after they receive your request. If the coverage request is denied, BCBSIL will let you and your prescriber (or authorized representative) know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination.

If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug, you, your prescriber, or your authorized representative, may be able to ask for an expedited review process. BCBSIL will let you, your prescriber (or authorized representative) know the coverage decision within 24 hours after they receive your request for an expedited review. If the coverage request is denied, BCBSIL will let you and your prescriber (or authorized representative) know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Call the number on the back of your ID card if you have any questions.

#### **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, epilepsy, and psoriasis are prescribed, your Physician will be required to obtain authorization from Blue Cross and Blue Shield in order for your medication to be eligible for 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.

Blue Cross and Blue Shield or its 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. Coverage will only be provided for Medically Necessary care. 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](http://www.bcbsil.com) or call the Customer Service toll-free number on your identification card.

### **Dispensing Limits**

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

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

If you require a Prescription Order in excess of the dispensing limit established by Blue Cross and Blue Shield, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. Blue Cross and Blue Shield reserves the right to change dispensing limits from time to time as medical/pharmacy research and prescribing patterns may indicate, and applied consistently based on clinical guidelines and maximum recommended dosing. Payment for benefits covered under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

### **Day Supply**

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

### **Controlled Substances Limitation**

If Blue Cross and Blue Shield determines that a Member may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized treatment guidelines, any coverage for additional drugs may be subject to a review for Medical Necessity, appropriateness and other coverage restrictions such as limiting coverage to prescription orders written by a certain Provider and/or dispensed by a certain Participating Pharmacy.

### **Extended Retail Prescription Drug Supply Program**

Your coverage includes benefits for up to a 90 day supply of maintenance type drugs and diabetic supplies purchased from a Participating Prescription Drug Provider (which may only include retail or home delivery pharmacies). Benefit payment amounts are listed in the Benefit Highlight Section. The payment levels described in the Benefit Highlights of this Certificate are for a 30 day supply. To find a list of Pharmacies participating in this program, refer to the Web site at [www.bcbsil.com](http://www.bcbsil.com).

Benefits will not be provided for a 90 supply drugs or diabetic supplies obtained from a Prescription Drug Provider not participating in the extended retail prescription drug supply program.

### **COVERED SERVICES**

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

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

Some drugs are manufactured under multiple brand names and have many therapeutic equivalents. Generic medications may also have several therapeutic equivalents. In such cases, Blue Cross and Blue Shield may limit benefits to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under this benefit section, the drug purchased will not be covered under any benefit level.

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

### **Injectable Drugs**

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

### **Immunosuppressant Drugs**

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

### **Fertility Drugs**

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

### **Diabetic Supplies for Treatment of Diabetes**

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

- Test strips specified for use with a corresponding blood glucose monitor
- Glucose test solutions
- Glucagon
- Glucose tablets
- 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
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

### **Vaccinations obtained through Participating Pharmacies**

Benefits for vaccinations are available through certain Participating Pharmacies that have contracted with Blue Cross and Blue Shield to provide this service. To locate one of these contracting Participating Pharmacies in your area and to find out which vaccinations are covered, call the Customer Service toll-free number on your identification card or access the Web site at [www.bcbsil.com](http://www.bcbsil.com). At the time you receive services, present your Blue Cross and Blue Shield identification card to the pharmacist. This will identify you as a participant in the Blue Cross and Blue Shield health care plan provided by your employer. The pharmacist will inform you of the amount for which you are responsible for, if any.

Each Participating Pharmacy that has contracted with Blue Cross and Blue Shield to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this Benefit Section. Refer to your Blue Cross and Blue Shield medical coverage for benefits available for childhood immunizations.

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

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

### **Self-Administered Cancer Medications**

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

**Breast Cancer Pain Medication and Therapy** — Benefits will be provided for all Medically Necessary pain medication related to the treatment of breast cancer. Benefits will also be provided for all Medically Necessary pain therapy related to the treatment of breast cancer under the PHYSICIAN BENEFIT SECTION of this policy.

### **Cancer Medications**

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

### **Specialty Drugs**

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

## **SELECTING A PHARMACY**

### **Preferred Participating Pharmacy**

When you choose to go to a Preferred Participating Pharmacy:

- present your identification card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- pay the applicable Deductible, if any, and
- pay the appropriate Copayment Amount or Coinsurance Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive. the difference in cost between the brand name drug and its generic equivalent will not be applied toward the medical out-of-pocket expense limit or the Prescription Drug out-of-pocket expense limit.

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

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

The level of benefits paid will be the highest level available under this Certificate when pharmaceutical services are received from a Preferred Participating Pharmacy Provider.

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

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access the Web site at [www.bcbsil.com](http://www.bcbsil.com) or call the Customer Service toll-free number on your identification card.

### **Participating Pharmacy**

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

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

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

### **Non-Participating Pharmacy**

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

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

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

### **Home Delivery Prescription Drug Program**

The Home Delivery Prescription Drug Program provides delivery of Covered Drugs directly to your home address. In addition to the benefits described in this Benefit Section, your coverage includes benefits for Maintenance Drugs and diabetic supplies obtained through the Home Delivery Prescription Drug Program. Some drugs may not be available through the Home Delivery Prescription Drug Program. For a listing of Maintenance Drugs or if you have any questions about the Home Delivery Prescription Drug Program,

need assistance in determining the amount of your payment, or need to obtain the home delivery order form, you may access the Web site at [www.bcbsil.com](http://www.bcbsil.com) or call the Customer Service toll-free number on your identification card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

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

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

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

### **Specialty Pharmacy Program**

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

The Specialty Pharmacy Program delivery service offers:

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

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

## **YOUR COST**

### **Deductible**

If you are responsible for a Coinsurance Amount, each benefit period you must satisfy the Participating Provider program deductible described in the Benefit Highlights of this Certificate for your medical benefits before your benefits will begin for drugs and diabetic supplies. Expenses incurred by you for Covered Services under this Benefit Section will also be applied towards the program Deductible.

## **BENEFIT PAYMENT FOR PRESCRIPTION DRUGS**

### **Retail Pharmacy**

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

When you obtain Covered Drugs (other than Specialty Drugs), including diabetic supplies from a Participating Pharmacy, benefits will be provided as shown in the Benefit Highlights section of this Certificate and will not apply to your calendar year deductible.

When you obtain Covered Drugs, including diabetic supplies from a Non-Participating Pharmacy (other than a Participating Pharmacy) benefits will be provided at 50% of the amount you would have received had you obtained Covered Drugs from a Participating Pharmacy minus the Copayment Amount or Coinsurance Amount.

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

### **Home Delivery Prescription Drug Program**

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

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

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

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

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

### **Specialty Pharmacy Program**

When you obtain covered Specialty Drugs from a Provider who is not a Specialty Pharmacy Provider, 50% of the amount you would have received had you obtained the Specialty Drugs from a Specialty Pharmacy Provider and will not apply to your calendar year deductible.

## EXCLUSIONS

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

1. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels,); and drugs or covered devices for which no valid Prescription Order is obtained.
2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, 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.
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 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 or as required by law or regulation. 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 Certificate. 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, or not Medically Necessary.

14. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted.
15. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
16. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
17. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined.
18. Athletic performance enhancement drugs.
19. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phenolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form, except when used to treat Medically Necessary Covered Services resulting from an organic disease or illness, injury or congenital defect.
20. Some drugs manufactured under multiple brand names and that have many therapeutic equivalents. Blue Cross and Blue Shield may limit benefits to specific equivalents.
21. Compound Drugs
22. Drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives.
23. Medications in depot or long acting formulations that are intended for use longer than the covered days supply amount.
24. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
25. Benefits will not be provided for any self-administered drugs dispensed by a Physician.
26. Any Legend Drug which is not listed on the Drug List unless specifically covered elsewhere in this Certificate and/or is required to be covered by applicable law or regulation.
27. Drugs determined by the Plan to have inferior efficacy or significant safety issues.



## EXCLUSIONS—WHAT IS NOT COVERED

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

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

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

- Services or supplies that are not specifically mentioned in this Certificate.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under this Certificate for a) the cost of routine patient care associated with Experimental/Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this Certificate if not provided in connection with a qualified clinical cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).
- Custodial Care Service.
- Long Term Care Service.
- Respite Care Service, except as specifically mentioned under the Hospice Care Program.
- Inpatient Private Duty Nursing Service.
- Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

- Special braces, specialized equipment, appliances, ambulatory apparatus, except as specifically mentioned in this Certificate.
- Blood derivatives which are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye which are not Medically Necessary, except as specifically mentioned in this Policy. This exclusion is not applicable to children as described in this Policy.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.
- Immunizations, unless otherwise specified in this Certificate.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate.
- Maintenance Care.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under this Certificate for Autism Spectrum Disorder(s).
- Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services, except as they relate to Autism Spectrum Disorder(s).
- Hearing aids, except for hearing aids for children or bone anchored hearing aids (osseointegrated auditory implants), examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Certificate.
- Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.
- Diagnostic Service as part of premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Experimental/Investigational unless otherwise specified in this Certificate.
- Reversal of vasectomies.
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Wigs (also referred to as cranial prostheses), unless otherwise specified in this Certificate.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.
- Abortions, including related services and supplies, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.
- Acupuncture, whether for medical or anesthesia purposes.
- Notwithstanding any provision in the Policy to the contrary, any services and/or supplies provided to you outside the United States, unless you receive Emergency Accident Care or Emergency Medical Care.

## COORDINATION OF BENEFITS SECTION

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

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

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

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

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

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

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

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

- (i) Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.
- (ii) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

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

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

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

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

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

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

## **ORDER OF BENEFIT DETERMINATION**

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

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

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

### **1. Non-Dependent or Dependent**

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

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

### **2. Dependent Child if Parents not Separated or Divorced**

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

- a. The benefits of the program of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the program of the parent whose birthday falls later in that year; but
- b. If both parents have the same birthday, the benefits of the Benefit Program that covered the parents longer are determined before those of the Benefit Program that covered the other parent for a shorter period of time.

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

### **3. Dependent Child if Parents Separated or Divorced**

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

- a. First, the program of the parent with custody of the child;
- b. Then, the program of the spouse of the parent with the custody of the child; and
- c. Finally, the program of the parent not having custody of the child.

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

4. Dependent Child if Parents Share Joint Custody

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

5. Active or Inactive Employee

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

6. Continuation Coverage

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

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

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

7. Length of Coverage

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

**WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM**

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

The benefits of this Benefit Program will be reduced when:

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

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

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

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

**RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

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

**FACILITY OF PAYMENT**

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

**RIGHT OF RECOVERY**

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

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

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

**CONTINUATION OF COVERAGE  
AFTER TERMINATION  
(Illinois State Laws)**

**This CONTINUATION OF COVERAGE AFTER TERMINATION section does not apply to Domestic Partners and their children.**

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the Eligible Person (see definitions) at the time of termination. The provisions described in Article B will apply if you are the spouse of or the party to a Civil Union with a retired Eligible Person and at least 55 years of age or former spouse of or the former party to a Civil Union with a retired Eligible Person who has died or from whom you have been divorced or no longer party to a Civil Union. The provisions described in Article C will apply if you are the dependent child of an Eligible Person who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided under Article B.

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

**ARTICLE A: Continuation of coverage if you are the Eligible Person**

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

1. Continuation of coverage will be available to you only if you have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least 3 months prior to your termination date or reduction in hours below the minimum required for eligibility.
2. Continuation of coverage will not be available to you if: (a) you are covered by Medicare, except if you have been covered under a group Medicare supplement policy, or (b) you have coverage under any other health care program which provides group hospital, surgical or medical coverage and under which you were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility, or (c) you decide to become a member of Blue Cross and Blue Shield on a "direct pay" basis.
3. If you decide to become a member of Blue Cross and Blue Shield on a "direct pay" basis, you may not, at a later date, elect the continuation of coverage option under this Certificate. Upon termination of the continuation of coverage period as explained in paragraph 6 below, the provisions of this Certificate pertaining to "Extension of Benefits in Case of Termination" will apply and you may exercise the Conversion Privilege explained in the ELIGIBILITY SECTION of this Certificate.
4. Within 10 days of your termination of employment or membership or reduction in hours below the minimum required for eligibility, your Group will provide you with written notice of this option to continue your coverage. If you decide to continue your coverage, you must notify your Group, in writing, no later than 30 days after your coverage has terminated or reduction in hours below the minimum required for eligibility or 30 days after the date you received notice from your Group of this option to continue coverage. However, in no event will you be entitled to your continuation of coverage option more than 60 days after your termination or reduction in hours below the minimum required for eligibility.

5. If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by Blue Cross and Blue Shield for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to Blue Cross and Blue Shield (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.
6. Continuation of coverage under this Certificate will end on the date you become eligible for Medicare, become a member of Blue Cross and Blue Shield on a “direct pay” basis or become covered under another health care program (which you did not have on the date of your termination or reduction in hours below the minimum required for eligibility) which provides group hospital, surgical or medical coverage. However, your continuation of coverage under this Certificate will also end on the first to occur of the following:
  - a. The date twelve months after the date the Eligible Person’s coverage under this Certificate would have otherwise ended because of termination of employment or membership or reduction in hours below the minimum required for eligibility.
  - b. If you fail to make timely payment of required charges, coverage will terminate at the end of the period for which your charges were paid.
  - c. The date on which the Group Policy is terminated. However, if this Certificate is replaced by similar coverage under another group policy, the Eligible Person will have the right to become covered under the new coverage for the amount of time remaining in the continuation of coverage period. When your continuation of coverage period has expired, the provisions of this Certificate entitled EXTENSION OF BENEFITS IN CASE OF TERMINATION (when applicable) will apply to you.

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

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

1. Continuation will be available to you as the former spouse of an Eligible Person or spouse of a retired Eligible Person only if you provide the employer of the Eligible Person with written notice of the dissolution of marriage or Civil Union, the death or retirement of the Eligible Person within 30 days of such event.
2. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to Blue Cross and Blue Shield of the dissolution of your marriage or Civil Union to the Eligible Person, the death of the Eligible Person or the retirement of the Eligible Person as well as notice of your address. Such notice will include the Group number and the Eligible Person’s identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents under this Certificate may be continued. Blue Cross and Blue Shield’s notice to you will include the following:
  - a. a form for election to continue coverage under this Certificate.
  - b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
  - c. instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.



3. In the event you fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Eligible Person under this Certificate as a result of the dissolution of marriage or Civil Union, the death or the retirement of the Eligible Person. Your right to continuation of coverage will then be forfeited.
4. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Eligible Persons under this Certificate.
5. If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:
  - a. an amount, if any, that would be charged to you if you were an Eligible Person, with Individual or Family Coverage, as the case may be, plus
  - b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

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

6. If you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.

7. Termination of Continuation of Coverage:

If you have not reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

- a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
  - b. on the date coverage would otherwise terminate under this Certificate if you were still married to or in a Civil Union with the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.
  - c. the date on which you remarry or enter into another Civil Union.
  - d. the date on which you become an insured employee under any other group health plan.
  - e. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:
    - a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
    - b. on the date coverage would otherwise terminate, except due to the retirement of the Eligible Person, under this Certificate if you were still married to or in a Civil Union with the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death, retirement or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.

- c. the date on which you remarry or enter another Civil Union.
  - d. the date on which you become an insured employee under any other group health plan.
  - e. the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.
9. If you exercise the right to continuation of coverage under this Certificate you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.
  10. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a “direct pay” basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.
  11. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

**ARTICLE C: Continuation of Coverage if you are the dependent child of an Eligible Person**

If the coverage of a dependent child should terminate because of the death of the Eligible Person and the dependent child is not eligible to continue coverage under ARTICLE B or the dependent child has reached the limiting age under this Certificate, the dependent child will be entitled to continue the coverage provided under this Certificate for himself/herself. However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the dependent child of an Eligible Person only if you, or a responsible adult acting on your behalf as the dependent child, provide the employer of the Eligible Person with written notice of the death of the Eligible Person within 30 days of the date the coverage terminates.
2. If continuation of coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the Eligible Person with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.
3. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to Blue Cross and Blue Shield of the death of the Eligible Person or of the dependent child reaching the limiting age, as well as notice of the dependent child’s address. Such notice will include the Group number and the Eligible Person’s identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield’s notice to you will include the following:
  - a. a form for election to continue coverage under this Certificate.
  - b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
  - c. instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.
4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a dependent child of an Eligible Person under this Certificate as a result of the death of the Eligible Person or the dependent child attaining the limiting age. Your right to continuation of coverage will then be forfeited.
5. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at

the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Eligible Persons under this Certificate.

6. The monthly charge will be computed as follows:
  - a. an amount, if any, that would be charged to you if you were an Eligible Person, plus
  - b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

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

7. Continuation of Coverage shall end on the first to occur of the following:
  - a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
  - b. on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the Eligible Person.
  - c. the date on which you become an insured employee, after the date of election, under any other group health plan.
  - d. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.
9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.
10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

## **CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION**

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

### **Continuation of Coverage**

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

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union partnership with the Eligible Person terminates. Your Civil Union partnership will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS SECTION of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

### **Conversion Privilege**

Upon termination of your continuation coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.

## **CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS**

The purpose of this section of your Certificate is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this Certificate as the Domestic Partner of an Eligible Person or as the dependent child of a Domestic Partner. Your continued coverage under this Certificate will be provided only as specified below. Please read the provisions very carefully. Note: Domestic Partner coverage is available at your Employer's discretion. Contact your Employer for information on whether Domestic Partner coverage is available for your Group.

### **Continuation of Coverage**

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this Certificate, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

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

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of "Domestic Partnership" in the DEFINITIONS SECTION of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

**This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to your dependent who is your Domestic Partner and their children.**

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

### Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

### What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

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

#### **When Is COBRA Coverage Available?**

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

#### **You Must Give Notice of Some Qualifying Events**

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

#### **How Is COBRA Coverage Provided?**

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### **Disability Extension Of 18-Month Period Of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

### **Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### **If You Have Questions**

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

### **Keep Your Plan Informed Of Address Changes**

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

### **Plan Contact Information**

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



## HOW TO FILE A CLAIM

In order to obtain your benefits under this Certificate, it is necessary for a Claim to be filed with Blue Cross and Blue Shield. To file a Claim, usually all you will have to do is show your Blue Cross and Blue Shield ID card to your Hospital or Physician (or other Provider) when you receive services. They will file your Claim for you. Remember however, it is your responsibility to insure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

Once Blue Cross and Blue Shield receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases Blue Cross and Blue Shield will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Group Administrator or from your local Blue Cross and Blue Shield office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

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

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

Should you have any questions about filing Claims, ask your Group Administrator or call your local Blue Cross and Blue Shield office.

### FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

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

1. Complete a prescription drug Claim Form. These forms are available from your Group Administrator or from your local Blue Cross and Blue Shield office.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois  
P.O. Box 14624  
Lexington, KY 40512-4624

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

#### **INITIAL CLAIMS DETERMINATIONS**

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

#### **If a Claim Is Denied or Not Paid in Full**

If the claim for benefits is denied you or your authorized representative shall be notified in writing of the following:

- a. The reasons for determination;
- b. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;
- c. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- d. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- e. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- f. In certain situations, a statement in non-English language(s) that written notices of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield;
- h. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- i. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- k. In the case of a denial of an Urgent Care Clinical claim a description of the expedited review procedure applicable to such claims. An Urgent Care Clinical claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification; and

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

## INQUIRIES AND COMPLAINTS

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

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

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

- Claims
- Quality of care

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

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

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

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written response to your Inquiry or Complaint within 30 days of receipt. Sometimes the acknowledgement and the response will be combined. If Blue Cross and Blue Shield needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information you will be contacted. 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.

1. **Urgent Care Clinical Claim** is any pre-service claim that requires Preauthorization, as described in this Benefit booklet, for benefit for medical care or Treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant 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 of Treatment.
2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. **Claim, also known as Post-Service Claim** is notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information with Blue Cross and Blue Shield may request in connection with services rendered to you.

### Urgent Care Clinical Claims\*

Type of Notice or Extension	Timing
-----------------------------	--------

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

\* You do not need to submit Urgent Care Clinical Claims in writing. You should call Blue Cross and Blue Shield at the toll-free number listed on the back of your ID 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**

<b>Type of Notice or Extension</b>	<b>Timing</b>
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
<i>Blue Cross and Blue Shield must notify you of the claim determination (whether adverse or not):</i>	
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 and 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 the Plan and (2) notifies you,

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

### Post-Service Claims

Type of Notice or Extension	Timing
If your claim is incomplete, Blue Cross and Blue Shield must notify you within:	30 days
If you are notified that your claim is incomplete, you must then provide completed claim information to Blue Cross and Blue Shield within:	45 days after receiving notice
<i>Blue Cross and Blue Shield must notify you of any adverse claim determination:</i>	
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 the Plan and (2) notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which Blue Cross and Blue Shield expects to render a decision.

### Concurrent Care

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

## CLAIM APPEAL PROCEDURES

### Claim Appeal Procedures — Definitions

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, in response to a Claim, pre-service Claim or Urgent Care Clinical Claim, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by Blue Cross and Blue Shield and Blue Cross and Blue Shield reduces or terminates such treatment (other than by amendment or termination of the Group’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission is also an Adverse Benefit Determination.

In addition, an Adverse Benefit Determination, also includes an “Adverse Determination.”

An “**Adverse Determination**” means:

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

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

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

### **Expedited Clinical Appeals**

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

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

### **How to Appeal an Adverse Benefit Determination**

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

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

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

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to Blue Cross and Blue Shield to request a claim review. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-877-284-9302 or send your request to:

Claim Review Section  
Health Care Service Corporation  
P.O. Box 2401  
Chicago, IL 60690-1364

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

Blue Cross and Blue Shield will provide you or your authorized representative with any new

or additional evidence or rationale and any other information and documents used in the denial or the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or 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 on medical judgment, the appeal will be conducted by individuals associated with Blue Cross and Blue Shield and/or external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by Blue Cross and Blue Shield.

#### **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 the appeal has been received by Blue Cross and Blue Shield, whichever is sooner.

Blue Cross and Blue Shield will render a decision of the 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.

If the appeal is related to administrative matters or Complaints, Blue Cross and Blue Shield will render a decision of a pre-service or post-service appeal as soon as practical, but in no event more than 60 business days after receipt of all required information.

#### **Notice of Appeal Determination**

Blue Cross and Blue Shield will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, 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 decision on internal appeal;
- e. In certain situations, a statement in non-English language(s) that written notices of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);

- f. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by 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; and
- j. A description of the standard that was used in denying the claim and a discussion of the decision.
- k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

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

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

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

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

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

**If You Need Assistance**

If you have any questions about the claims procedures or the review procedure, write or call Blue Cross and Blue Shield at 1-800-538-8833. Blue Cross and Blue Shield offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday.

Blue Cross and Blue Shield of Illinois  
 P.O. Box 2401  
 Chicago, IL 60690-1364

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at, 1-877-527-9431 or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).



## **INDEPENDENT EXTERNAL REVIEW**

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

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

### **1. Standard External Review**

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

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

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

For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Blue Cross and Blue 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, IRO, you, and if applicable, your authorized representative of its decision to reverse the determination.

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

- Your pertinent medical records;
- Your health care provider's recommendation;
- Consulting reports from appropriate health care providers and other documents submitted to Blue Cross and Blue Shield or its designee utilization review organization, you, your authorized representative or your treating provider;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield or its designated utilization review organization; and
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

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

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

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

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 the majority of the clinical reviewers.

The written notice will include:

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

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

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

will receive written notice from the IRO. If you disagree with the determination of the IRO, you may appeal the decision of the IRO to the Illinois Department of Insurance.

### Standard External Review

Standard External Review	Timing
If you receive an Adverse Determination or a Final Adverse Determination, you may file a request for an external review within:	4 months after receipt of notice
Blue Cross and Blue Shield shall complete a preliminary review of the request within:	5 business days after receiving request
<i>Blue Cross and Blue Shield must notify you whether the request is complete and eligible for external review:</i>	
if the request is not complete Blue Cross Blue Shield shall notify you and include what information or materials are required within:	1 business day after the preliminary review
if the request is not eligible for external review Blue Cross Blue Shield shall notify you and include the reasons for its ineligibility within:	1 business day after the preliminary review
Blue Cross Blue Shield shall notify the Director, you or your authorized representative that a request is eligible for external review within:	1 business day after the preliminary review
The Director shall assign an independent review organization (IRO) within:	1 business day after receipt of the notice.
Blue Cross 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**

<b>Expedited External Review</b>	<b>Timing</b>
You may file a request for an expedited external review after the date of receipt of a notice prior to Final Adverse Determination:	immediately
You may file a request for an expedited external review if Blue Cross and Blue Shield fails to provide a decision on a request for an expedited internal appeal within:	48 hours
<i>Blue Cross and Blue Shield must immediately notify the Director, you or your authorized representative whether the request is complete and eligible for an expedited external review or is ineligible for review and may be appealed to the Director. The Director may make a determination that the request is eligible for an expedited external review, notwithstanding Blue Cross and Blue Shield's determination.</i>	
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
<i>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.</i>	
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 or your authorized representative:	as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the receipt of request.

**External Review of Experimental or Investigational Treatment**

<b>Experimental or Investigational Treatment External Review</b>	<b>Timing</b>
--	---------------

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
<i>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.</i>	
After the receipt for an external review, the Director shall send a copy of the request to Blue Cross and Blue Shield within:	1 business day
Blue Cross and Blue Shield shall complete a preliminary review of the request within:	5 business days
After completion of the preliminary review, Blue Cross and Blue Shield shall notify you or your authorized representative and the Director whether the request is complete and eligible for external review within:	1 business day
<i>When the Director receives notice that the request is eligible for external review, the Director shall:</i>	
assign an IRO and notify Blue Cross and Blue Shield of the name of the IRO, within:	1 business day
notify you or your authorized representative in writing of the request's eligibility and acceptance for external review and the name of the IRO, within:	1 business day
If you are notified that your request for an external review has been accepted, you or your authorized representative may submit additional information to the assigned IRO within:	5 business days
The assigned IRO shall then select one or more clinical reviewers within:	1 business day
Blue Cross and Blue Shield shall provide to the assigned IRO the documents and any information used in making the Adverse Determination or Final Adverse Determination within:	5 business days of notice of assigned IRO
After being selected by the assigned IRO, each	20 days

clinical reviewer shall provide an opinion to the assigned IRO on whether the recommended or requested health care service shall be covered within:	
or, in the case of an expedited external review:	immediately, but in no event more than 5 calendar days
The assigned IRO shall make a decision after receipt of the opinion from each clinical reviewer and provide notification of the decision to the Director, you or your authorized representative and 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

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination; (b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received Emergency Services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of Final Adverse Determination or if Blue Cross and Blue Shield fails to provide a decision on request for an expedited internal appeal within 48 hours.

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

Expedited external review will not be provided for retrospective adverse or final adverse determinations. Your request for an expedited independent external review may be submitted to the Director either orally (by calling 1-877-850-4740) or in writing as set forth above for requests for standard external review.

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

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

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

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

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

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

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

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





## PEDIATRIC DENTAL BENEFIT SECTION

### COVERED SERVICES

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

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

Your Dental benefits include coverage for the following Covered Services as long as these services are rendered to you by a Physician or a Dentist. When the term “Dentist” is used in this Certificate, it will mean Physician or Dentist.

### Diagnostic Evaluations

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

- Periodic oral evaluations for established patients.
- Problem focused oral evaluations, whether limited, detailed or extensive.
- Comprehensive oral evaluations for new or established patients.
- Comprehensive periodontal evaluations for new or established patients.
- Oral evaluations of children, including counseling with primary caregiver.
- Oral Examinations— The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every Benefit Period in the dental office and once every 12 months in a school setting.

Benefits will not be provided for comprehensive periodontal evaluations or problem focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist. Benefits will not be provided for tests and oral pathology procedures, or for reevaluations.

### Preventive Services

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

- Prophylaxis—Professional cleaning, scaling and polishing of the teeth. Benefits will be limited to two cleanings every 12 months. Additional Benefits will be provided for prophylaxis based on degree of difficulty.
- Topical Fluoride Application—Benefits for Fluoride Application is only available to covered persons under age 19 and are limited to two applications every 12 months.

### Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Combination of prophylaxes and periodontal maintenance treatments (see “Non-Surgical Periodontic Services”) are limited to two every 12 months.

### **Diagnostic Radiographs**

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

- Full-mouth (intraoral complete series) and panoramic films - Benefits are limited to a combined maximum of one every 36 months.
- Bitewing films - Benefits are limited to four horizontal films or eight vertical films once every 12 months. However, Benefits are not available for bitewing films taken on the same date as full-mouth films.
- Periapical films, as necessary for diagnosis - Benefits are limited to six every 12 months.

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular joint (TMJ) Dysfunction.

### **Miscellaneous Preventive Services**

Miscellaneous preventive services are other services performed to prevent dental disease and include:

- Sealants—Benefits for sealants are limited to one per permanent molar per lifetime and are available to covered persons under age 19.
- Space Maintainers—Benefits for space maintainers are limited to a lifetime maximum of one appliance per missing tooth site for Subscribers up to age 19.

Benefits are not available for nutritional, tobacco or oral hygiene counseling.

### **Basic Restorative Dental Services**

Basic Restorative services are restorations necessary to repair dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Covered Services include:

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

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

### **Non-Surgical Extractions**

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

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

### **Non-Surgical Periodontal Services**

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

- Periodontal scaling and root planing—Benefits are limited to one per quadrant every 24 months.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once every 12 months.
- Periodontal maintenance procedures—Benefits are limited to two every 12 months in combination with routine oral prophylaxis and must be performed following active periodontal treatment.

Benefits will not be provided for chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy.

### **Adjunctive Services**

Adjunctive general services include:

- Palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment.
- Deep sedation/general anesthesia and intravenous sedation/non-intravenous conscious sedation—by report only and when determined to be Medically Necessary for documented persons with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Medical Necessity.
- Nitrous Oxide analgesia will be covered for Eligible persons under age 19.
- Therapeutic parenteral Drug Injections will be covered for Eligible persons under age 19.

Benefits will not be provided for local anesthesia or other drugs or medicaments and/or their application.

### **Endodontic Services**

Endodontics is the treatment of dental disease of the tooth pulp and includes:

- Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure.
- Root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.
- Apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputations and hemisection.

Pulpal debridement is considered part of endodontic therapy when performed by the same Provider and not associated with a definitive emergency visit.

Benefits will not be provided for the following “Endodontic Services”:

- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of performed dowel and post, or post removal.
- Endodontic therapy if you discontinue endodontic treatment.

### **Oral Surgery Services**

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

- Surgical tooth extraction

- Alveoloplasty and vestibuloplasty
- Excision of benign odontogenic tumor/cysts.
- Excision of bone tissue.
- Incision and drainage of an intraoral abscess.
- Other Medically Necessary surgical and repair procedures not specifically excluded in this Certificate.

Intraoral soft tissue and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered part of the procedure.

Benefits will not be provided for the following Oral Surgery procedures:

- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.

### **Surgical Periodontal Services**

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and include:

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planing)—Benefits are limited to one quadrant every 24 months.
- Clinical crown lengthening.
- Osseous surgery, including flap entry and closure—Benefits are limited to one per quadrant every 24 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.
- Osseous grafts—Benefits are limited to one per site every 24 months.
- Soft tissue grafts/allografts (including donor site)—Benefits are limited to one per site every 24 months.
- Distal or proximal wedge procedure.
- Anatomical crown exposures—Benefits are limited to one per quadrant every 24 months.

Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores, or basic restorations are considered part of the restoration.

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

### **Major Restorative Services**

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

- Single crown restorations.
- Gold foil and inlay/onlay restorations.
- Labial veneer restorations.

Benefits will be provided for the replacement of a lost or defective crown. However, Benefits will not be provided for the restoration of occlusion on incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 months, even if the original crown was stainless steel. Crowns placed over implants will be covered.

### **Prosthodontic Services**

Prosthodontics involve procedures necessary for providing artificial replacements for missing natural teeth and includes:

- Complete (upper and lower dentures) and removable partial dentures (upper and lower dentures)—Benefits will be provided for the initial installation of removable complete, immediate or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 60-month period. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss.
- Denture reline/rebase procedures—Benefits will be limited to one procedure every 24 months.
- Fixed bridgework (fixed prosthetics)—Benefits will be provided for the initial installation of a bridgework, including inlays/onlays and crowns.
- Benefits will be limited to once every 60 months.
- Maxillofacial Prosthetics

Prosthetics placed over implants will be covered.

Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

Benefits will not be provided for the following Prosthodontic Services:

- Treatment to replace teeth which were missing prior to the Effective Date, except those teeth missing due to congenital malformation.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

## Miscellaneous Restorative and Prosthodontic Services

Other restorative and prosthodontics services include:

- Prefabricated crowns—Benefits for stainless steel and resin-based crowns are limited to one per tooth every 60 months. These crowns are not intended to be used as temporary crowns.
- Recementation of inlays/onlays, crowns, bridges, and post and core—Benefits will be limited to two recementations every 12 months. However, any recementation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.
- Post and core, pin retention, and crown and bridge repair services.
- Pulp cap—direct and indirect.
- Adjustments—Benefits will be limited to three times per appliance every 12 months.
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp (unless additions are completed on the same date as replacement partials/dentures) are limited to a lifetime maximum of once per tooth or clasp.

## Orthodontic Dental Services

Orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth. Your Covered Services for orthodontics are shown on your ***Benefit Highlights***. Covered services include:

- Diagnostic orthodontic records and radiographs **limited to a lifetime maximum of once per person.**
- Limited, interceptive and comprehensive orthodontic treatment.
- Orthodontic retention, **limited to a lifetime maximum of one appliance per person.**

## Special Provisions Regarding Orthodontic Services:

Pediatric Orthodontic Services—Coverage is limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion) or meeting or exceeding a score of 42 from the Modified Salzmann Index.

- Orthodontic services are paid over the Course of Treatment, up to the maximum Benefit Period orthodontic Benefit. Benefits cease when you are no longer covered, whether or not the entire Benefit has been paid out.
- Orthodontic treatment is started on the date the bands or appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the Benefit Period maximum for orthodontic services.
- If orthodontic treatment is terminated for a reason before completion, Benefits will cease on the date of termination.
- If your coverage is terminated prior to the completion of the orthodontic treatment plan, the Insured is responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Subscriber is not covered.
- Benefits are not available for replacement or repair of an orthodontic appliance.
- For services in progress on the Effective Date, Benefits will be reduced based on the benefits paid prior to this coverage beginning.

**Implant Placement Surgery**

Covered Services include the surgical placement, maintenance and repair of an implant body, including services associated with preparation of the implant site (e.g., splinting, grafting).



## PEDIATRIC DENTAL EXCLUSIONS AND LIMITATIONS

These general *Exclusions and Limitations* apply to all services described in this dental Contract. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (as defined in the *Definitions* section) licensed to perform services covered under this dental Plan.

### IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

#### Dental Procedures Which Are Not Medically Necessary

**Please note that in order to provide you with dental care Benefits at a reasonable cost, this Plan provides Benefits only for those Covered Services for eligible dental treatment that are determined to be Medically Necessary.**

No Benefits will be provided for procedures which are not Medically Necessary. Medically Necessary generally means that a specific procedure provided to you is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you.

The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

#### Care By More Than One Dentist

If you change Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of Benefits.

#### Alternate Benefits

In all cases in which there is more than one Course of Treatment possible, the Benefit will be based upon the most efficient Course of Treatment.

If you and your Dentist or Physician decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the Benefit for the standard procedures for dental services.

#### Non-Compliance with Prescribed Care

Any additional treatment and resulting liability which is caused by the lack of your cooperation with the Dentist or from noncompliance with prescribed dental care will be your responsibility.

### EXCLUSIONS - WHAT IS NOT COVERED

No Benefits will be provided under this Plan for:

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

- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve aesthetics.
- Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Certificate.
- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders or to increase vertical dimension.
- Dental services which are performed due to an accidental injury, except for persons under age 19. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury.
- Services and supplies for any illness or injury suffered after your Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental, Investigational and/or unproven services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- 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.
- Services or supplies for which “discounts” or waiver of Deductible or Coinsurance amounts are offered.
- Services rendered by a Dentist related to you by blood or marriage.
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Services or supplies received for behavior management or consultation purposes.
- Charges for nutritional, tobacco or oral hygiene counseling.
- Charges for local, state or territorial taxes on dental services or procedures
- Charges for the administration of infection control procedures as required by local, state or federal mandates.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a Claim form or forwarding requested records or x-rays.
- Charges for prescription or nonprescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.

- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your Effective Date under this Plan; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after your Effective Date.
- Charges for occlusion analysis or occlusal adjustments.
- Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
- Case presentations or detailed and extensive treatment planing when billed for separately.

The Plan may, without waiving these exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the exclusions listed above. If it is later determined that the care and services are excluded from your coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Plan. You must provide the Plan with all documents it needs to enforce its rights under this provision.

## GENERAL PROVISIONS

### 1. BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers ("Plan Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under certain circumstances described in its contracts with Plan Providers, Blue Cross and Blue Shield may:

- receive substantial payments from Plan Providers with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Plan Provider, or
- pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Plan Providers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Certificate and the calculation of all required deductible and Coinsurance amounts payable by you under this Certificate shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Group has been advised that Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Providers work, please consider the following example:

- a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is \$1,000. How is the \$1,000 bill paid?
- b. You personally will have to pay the deductible and Coinsurance amounts set out in your Certificate.
- c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the \$1,000 Hospital bill would be reduced by 30% to \$700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.
- d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the \$1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of \$700, or \$140. You should note that your 20% Coinsurance is based on the full \$1,000 Hospital bill, after it is reduced by the applicable ADP.
- e. After taking into account the deductible and Coinsurance amounts, Blue Cross and Blue Shield will satisfy its portion of the Hospital bill. In most cases, Blue Cross and Blue Shield has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money Blue Cross and Blue Shield would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is \$1,000, your deductible has already been satisfied, and your Coinsurance is \$140, then Blue Cross and Blue Shield has to satisfy the rest

of the Hospital bill, or \$860. Assuming Blue Cross and Blue Shield has a contract with the Hospital, Blue Cross and Blue Shield will usually be able to satisfy the \$860 bill that remains after your Coinsurance and deductible, by paying less than \$860 to the Hospital, often substantially less than \$860. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the \$860 bill and whatever Blue Cross and Blue Shield ultimately pays under its contracts with Plan Providers, and neither you nor your Group are entitled to any part of these savings.

### **Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers**

#### **Out-of-Area Services**

Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, herein called "the Plan" has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you access healthcare services outside of the Plan's service area, the claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program and may include negotiated National Account arrangements available between the Plan and other Blue Cross and Blue Shield Licensees.

When you receive care outside our service area, you will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. We explain how we pay both types of Providers below.

#### **A. BlueCard® Program**

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you receive Covered Services outside the Plan's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to the Plan.

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

- a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your identification card to the Provider to let him or her know that you are covered by the Plan.
- b. The provider has negotiated with the Host Blue a price of \$80, even though the Provider's standard charge for this service is \$100. In this example, the Provider bills the Host Blue \$100.
- c. The Host Blue, in turn, forwards the claim to the Plan and indicates that the negotiated price for the Covered Service is \$80. The Plan would then base the amount you must pay for the service - the amount applied to your Deductible, if any, and your coinsurance percentage - on the \$80 negotiated price, not the \$100 billed charge.
- d. So, for example, if your coinsurance is 20%, you would pay \$16 (20% of \$80), not \$20 (20% of \$100). You are not responsible for amounts over the negotiated price for a Covered Service.

**PLEASE NOTE:** The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your Deductible and that there are no Copayments associated with the service rendered. Your Deductible(s), Coinsurance and Copayment(s) are specified in this Certificate.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied after a claim has already been paid.

**B. Negotiated (non-BlueCard Program) Arrangements**

As an alternative to the BlueCard Program, your claims for Covered Services may be processed through a Negotiated Arrangement for National Account with a Host Blue.

The amount you pay for Covered Services under this arrangement will be calculated based on lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to the Plan by the Host Blue.

**C. Non-Participating Healthcare Providers Outside the Plan’s Service Area**

**a. Liability Calculation**

(1) In General

When Covered Services are provided outside of the Plan’s service area by Non-Participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Certificate for non-Participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

(2) Exceptions

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

**D. Special Cases: Value-Based Programs**

BlueCard<sup>®</sup> Program

If you receive Covered Services under a Value-Based Program inside a Host Blue’s service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Plan through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If the Plan has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Qualified Employer on your behalf, the Plan will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted for the BlueCard Program.

**E. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

## F. BlueCard Worldwide<sup>®</sup> Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), you may be able to take advantage of the BlueCard Worldwide<sup>®</sup> Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact the Plan to obtain preauthorization for non-emergency inpatient services.**

- **Outpatient Services**

Outpatient Services are available for Emergency Care. Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a BlueCard Worldwide Claim**

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the Provider’s itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Plan the BlueCard Worldwide Service Center or online at [www.bluecardworldwide.com](http://www.bluecardworldwide.com). If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

### **Blue Cross and Blue Shield’s Separate Financial Arrangements 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 Certificate. 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. Actual discounts used to calculate your share of the cost of Prescription Drugs will vary. Some discounts are currently based on Average Wholesale Price (“AWP”) which is determined by a third party and is subject to change.

You understand that Blue Cross and Blue Shield may receive such discounts. Neither the Group nor you are entitled to receive any portion of any discounts. The drug fees/discounts that Blue Cross and Blue Shield has negotiated with Prime Therapeutics LLC (“Prime”) through the Pharmacy Benefit Management (“PBM”) Agreement, will be used to calculate your share of the cost of Prescription Drugs for both retail and home delivery/specialty drugs. Except for home delivery/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to the Plan (and ultimately to you as described above).

Coinsurance amounts payable by you under this Certificate will be calculated on the basis of the provider’s eligible charge or the agreed upon cost between the Participating Prescription Drug Provider and Blue Cross and Blue Shield for a prescription drug, whichever is lower.

To help you understand how Blue Cross and Blue Shield’s separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

- a. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is \$100. How is the \$100 bill paid?
- b. You personally will have to pay the Coinsurance amount set out in this Certificate.
- 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.

For the home delivery pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the home delivery pharmacy and/or specialty pharmacy program. The Plan pays a fee to Prime for pharmacy benefit services. A portion of Prime’s PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and home deliver processing.

“Weighted Paid Claim” refers to the methodology of counting claims for purposes of determining Blue Cross and Blue Shield’s fee payment to Prime. Each retail (including claims dispensed through PBM’s specialty pharmacy program) paid claim equals one Weighted Paid Claim; each extended supply or home deliver order paid claim equals three Weighted Paid Claims. However, Blue Cross and Blue Shield pays Prime a Program Management Fee (“PMF”) on a per paid claim basis. “Funding Levers” means a mechanism through which the Plan funds the fees (net fee, ancillary fees and special project fees) owed to PBM. Funding Levers always include manufacturer administrative fees, home delivery utilization, participating pharmacy transaction fees, and, if elected by the Plan, may include rebates and retail spread. The Plan’s net fee owed to Prime for core services will be offset by the Funding Levers. The Plan pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per Weighted Paid Claim.

The amounts received by Prime from the Plan, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Plan (as described above), administrative fees charged by Prime to pharmacies, and administrative



fees charged by prime to pharmaceutical manufactures. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Certificate. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacture for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacture dispensed during any given calendar year to members of the Plan and other Blue Plan operating divisions.

### **Blue Cross and Blue Shield's Separate Financial Arrangements with Pharmacy Benefit Managers**

Blue Cross and Blue Shield owns a significant portion of the equity of Prime Therapeutics LLC and informs you that Blue Cross and Blue Shield has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on Blue Cross and Blue Shield's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Plan, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufactures to cover the administrative costs of processing late payments). The Plan may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

## **2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS**

- a. Under this Certificate, Blue Cross and Blue Shield has the right to make any benefit payment either directly to the Provider of the Covered Services or to you, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by the Plan sufficiently in advance of the Plan's benefit payment. The Plan reserves the right to require submission of a copy of the Assignment of Benefit Payment. For example, Blue Cross and Blue Shield may pay benefits to you if you receive Covered Services from a Non-Plan Provider. Blue Cross and Blue Shield is specifically authorized by you to determine to whom any benefit payment should be made.
- b. Once Covered Services are rendered by a Provider, you have no right to request Blue Cross and Blue Shield not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, Blue Cross and Blue Shield will have no liability to you or any other person because of its rejection of such request.
- c. Except for the Assignment of Benefit Payment described above, either this Certificate or a Covered Person's claim for benefits under this Certificate is expressly non-assignable and non-transferable to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a Covered Person, and Coverage under this Certificate is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

## **3. YOUR PROVIDER RELATIONSHIPS**

- a. The choice of a Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.
- b. Blue Cross and Blue Shield does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. Blue Cross and Blue Shield is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by Blue Cross and

Blue Shield. Any contractual relationship between a Physician and a Plan Hospital or other Plan Provider shall not be construed to mean that Blue Cross and Blue Shield is providing professional service.

- c. The use of an adjective such as Plan or Participating in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Plan, Participating or any similar modifier or the use of a term such as Non-Plan or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.
- d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Group (other than as an individual Covered Person) or your Group's ERISA Health Benefit Program.

#### **4. AGENCY RELATIONSHIPS**

The Group is your agent under this Certificate. The Group is not the agent of Blue Cross and Blue Shield.

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

#### **5. NOTICES**

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

#### **6. LIMITATIONS OF ACTIONS**

No legal action may be brought to recover under this Certificate, prior to the expiration of sixty (60) days after a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate.

#### **7. INFORMATION AND RECORDS**

You agree that it is your responsibility to ensure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Certificate, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield or its agent, and agree that any such Provider, person or other entity may furnish to Blue Cross and Blue Shield or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish Blue Cross and Blue Shield and/or your employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that Blue Cross and Blue Shield be able to make Claim Payments in accordance with MSP laws.

## **8. VALUE BASED DESIGN PROGRAMS**

Blue Cross and Blue Shield and your employer has the right to offer health behavior wellness, maintenance, or improvement programs that allow for a reward, a contribution, a penalty, a differential in premiums or in medical, prescription drug or equipment Copayments, Coinsurance, deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by Blue Cross and Blue Shield, or an entity chosen by Blue Cross and Blue Shield to administer such programs. In addition, discount programs for various health and wellness-related or insurance-related items and services may be available from time-to-time. Such programs may be discontinued with or 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.

Contact your employer for additional information regarding any value based programs offered by your employer.

## **9. CONFORMITY WITH STATE STATUTES**

This Certificate provides, at a minimum, coverage as required by Illinois law. Laws in some other states require that certain benefits or provisions be provided to you if you are a resident of their state when the policy that insures you is not issued in your state. In the event any provision of this Certificate, on its effective date, conflicts with the laws of the state in which you permanently reside, you will be provided the greater of the benefit under this Certificate or that required under the laws of the state in which you permanently reside.

## **10. MEMBER DATA SHARING**

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

## **11. RELIGIOUS EMPLOYER EXEMPTION AND ELIGIBLE ORGANIZATION**

### **ACCOMMODATION**

A certification(s) may have been provided to BCBSIL that your group health plan is established or maintained by an organization(s) that is a "religious employer(s)" as defined in 45 C.F.R. 147.131(a), as modified or replaced, and qualifies for a religious employer exemption from the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Religious Employer Exemption").

Provided that the Religious Employer Exemption is satisfied for your group health plan, then coverage under your group health plan will not include coverage for some or all of such contraceptives services. Please call Customer Service at the number on the back of your ID card for more information. Questions regarding the Religious Employer Exemption should be directed to your Group.

In addition, a certification(s) may have been provided to BCBSIL that your group health plan is established or maintained by an organization(s) that is an "eligible organization(s)" as defined in 45 C.F.R. 147.131(b), as modified or replaced, and qualifies for an eligible organization accommodation with respect to the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Eligible Organization Accommodation"). Provided that the Eligible Organization Accommodation is satisfied, coverage under your group health plan will not include coverage for some or all of such contraceptives services. Please call Customer Service at the number on the back of your ID card for more information. If you have questions regarding the certification(s), you may contact your Group. For other questions about the Eligible Organization Accommodation, you may contact Customer Service at the number on the back of your ID card.

## **12. ENTIRE CONTRACT**

The entire contract consists of Group Policy, including the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, the Group's application and the Plan, as appropriate, along with any exhibits, appendices, addenda and/or other required information and the individual Application(s) of the persons covered under the Policy, benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the Application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written Application.

No agent has the authority to modify or waive any part of the Group Policy, to extend the time for payment of premiums, or to waive any of the rights or requirements of Blue Cross and Blue Shield. No modifications of the Group Policy will be valid unless evidenced by an endorsement or amendment of the Group Policy, signed by an executive officer of Blue Cross and Blue Shield and delivered to the Group.

## **REIMBURSEMENT PROVISION**

If a covered person recovers expenses for sickness or injury that occurred due to the negligence of a third party, We have the right to first reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, the covered person's parents if the covered person is a minor, or the covered person's legal representative as a result of that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.



**BlueCross BlueShield of Illinois**

*Experience. Wellness. Everywhere.™*

*Plan Name: Blue Options and Participating Option*

**[www.bcbsil.com](http://www.bcbsil.com)**

*A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,  
an Independent Licensee of the Blue Cross and Blue Shield Association*