Your Health Care Benefit Program

Egyptian Area Schools Employee Benefit Trust

Plan A -240874
Plan B – 240875
Plan C – 240876
Plan E1 – 240878
Plan AB1 – 240879
Plan M3 – 240880
Plan M6 – 240881
Plan M7 – 240882
Plan M8 - 240883

Administered by:

BlueCross BlueShield of Illinois

GENERAL PLAN INFORMATION

INTRODUCTION

The Plan Sponsor has established the Plan for the benefit of eligible Employees of public school districts in Illinois in accordance with the terms and conditions described in this document. Plan benefits are self-funded through a trust fund established by the Plan Sponsor and funded with contributions from Participants and Participating Employers. Participants in the Plan may be required to contribute toward their benefits in amounts determined by their Employers.

This benefit booklet sets forth the terms and provisions of the Plan for the payment or reimbursement of eligible expenses incurred on or after March 1, 2019. The Plan offers several plans of benefits, designated by the Plan letters and numbers shown on the cover page of this booklet. The specific benefit levels for each plan of benefits – the deductibles, Copayments, Coinsurance and out-of-pocket limits – are described in the **Schedule of Benefits** and the **Summary of Benefits and Coverage** (**SBC**) for each benefit plan. Your Employer determines the benefit plans available to its Employees. Copies of this benefit booklet and the Schedules of Benefits and SBCs for all benefit plans are available on the Trust website at www.egtrust.org or from your Employer.

IF YOU HAVE QUESTIONS

- **Benefits for Services on or after March 1, 2019.** If you have questions about your benefits or claims for services incurred on or after March 1, 2019, please contact your ***Benefits Value Advisor at BlueCross BlueShield of Illinois at 1-855-686-8517.***
- **Benefits for Services before March 1, 2019.** If you have questions about your benefits or claims for services incurred before March 1, 2019, please contact ***HealthSCOPE Benefits Customer Care at 1- 800-397-9598.***
- **Eligibility and Enrollment.** If you have questions about eligibility or enrollment, please contact your Employer.
- **COBRA.** If you have questions about COBRA Continuation Coverage, please contact ***HealthSCOPE Benefits COBRA line at 1-877-385-8775.***

GENERAL PLAN INFORMATION

Plan Sponsor: **(Named Fiduciary)**	**Board of Managers** **Egyptian Area Schools Employee Benefit Trust** **P. O. Box 2034** **Loves Park, IL 61130** Each Participating Employer selects a representative to serve on the Board of Managers. You may obtain the name and address of the representative of your Employer from your Employer.
Plan Administrator:	**Board of Managers** **Egyptian Area Schools Employee Benefit Trust** **P. O. Box 2034** **Loves Park, IL 61130**
Plan Sponsor ID No. (EIN):	**37-1156166**
Plan Status:	**Non-Grandfathered**
Plan Year:	**September 1 through August 31**
Claims Administrator:	**BlueCross BlueShield of Illinois** **300 East Randolph** **Chicago, IL 60601** **1-855-686-8517**

Enrollment Administrator:	**HealthSCOPE Benefits, Inc.** **27 Corporate Hill Drive** **Little Rock, AR 72205** **1-800-323-6042** (for bookkeepers only)
COBRA Administrator:	**HealthSCOPE Benefits, Inc.** **P. O. Box 2459** **Little Rock, AR 72203** **1-877-385-8775**
Participating Employers:	**Contact your Employer or HealthSCOPE Benefits to determine if your Employer is a Participating Employer in the Trust.**
Source of Funding:	**Self-Funded** Contributions are made to the Plan by the Employers and Employees and are accumulated in a trust fund from which benefits are paid. Each Participating Employer determines the contribution, if any, that must be paid by its Employees.
Agent for Service of Process:	**Chairman, Board of Managers** **Egyptian Area Schools Employee Benefit Trust** **P. O. Box 2034** **Loves Park, IL 61130**

NO CONTRACT OF EMPLOYMENT

This benefit booklet and any amendments, together with the Schedule of Benefits and SBC for each plan of benefits, constitute the legal Plan document and the terms and provisions of coverage under this Plan. The Plan document shall not be deemed to constitute a contract of employment or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan document shall be deemed to give any Employee the right to be retained in the service of any Participating Employer or to interfere with the right of the Participating Employer to discharge any Employee at any time.

APPLICABLE LAW

The Plan is a self-funded nonfederal governmental plan which is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and Employer contributions and is subject to applicable Federal and Illinois State laws.

DISCRETIONARY AUTHORITY

The Plan Sponsor shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participant's rights; and to determine all questions of fact and law arising under the Plan.

A message from

Egyptian Area Schools Employee Benefit Trust

This booklet describes the Health Care Plan the Egyptian Trust and your Employer provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please carefully read the information in this benefit booklet and the Schedule of Benefits and Summary of Benefits and Coverage for your plan of benefits so you will have a full understanding of your health care benefits.

If you want more information or have any questions about your health care benefits, please contact the Benefits Value Advisor at 1-855-686-8517.

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator 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 "Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator 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 "Claim Administrator's Separate Financial Arrangements with Prescription Drug Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

You should be aware that when you elect to utilize the services of a Non- Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE 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 Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

TABLE OF CONTENTS

DEFINITIONS SECTION

Throughout this benefit booklet, 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 benefit booklet, 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.

ACUPUNCTURIST…means a duly licensed acupuncturist operating within the scope of his or her license.

ACUTE TREATMENT SERVICES…means a 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

ADMINISTRATOR HOSPITAL…SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM…means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/ or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER…SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE...means 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 specially equipped certified ground and air ambulance options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this health care plan.

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE...means i) for ambulance providers that bill for Ambulance Transportation services through a Participating Hospital the Ambulance Transportation Eligible Charge is the applicable ADP, and ii) for all other ambulance providers, the Ambulance Transportation Eligible Charge is such provider's Billed Charge.

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

> An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.
>
> A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator 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 preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

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

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

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

AVERAGE DISCOUNT PERCENTAGE ("ADP")...means a percentage discount determined by the Claim Administrator 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 maxi- mums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator'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 benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator'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 the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH UNIT...means a unit established to assist in the administration of Mental Illness and Substance Use Disorder 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.

BILLED CHARGES…means the total gross amounts billed by Providers to the Claim Administrator on a Claim, which constitutes the usual retail price that the Provider utilizes to bill patients or any other party that may be responsible for payment of the services rendered without regard to any payor, discount or reimbursement arrangement that may be applicable to any particular patient. This list of retail prices is also sometimes described in the health care industry as a "chargemaster."

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

CARE COORDINATION FEE…means a fixed amount paid by a Blue Cross and/or Blue Shield plan to Providers.

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

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

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

A "Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator 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 the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse-Midwife" means a Certified Nurse- Midwife who does not have a written agreement with the Claim Administrator 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 has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator 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 has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who does not have a written agreement with the Claim Administrator 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 and is 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 the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR…means Blue Cross and Blue Shield of Illinois.

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 the Claim Administrator and a particular Provider. (See provisions regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

CLAIM PAYMENT...means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. 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 the Claim Administrator and a particular Provider. (See provisions regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

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 the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan 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 has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Professional Counselor" means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator 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 has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Social Worker" means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL STABILIZATION SERVICES...means a 24-hour treatment, usually following acute treatment services for Substance Use Disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

CLINICIAN…means a person operating within the scope of his/her license, registration or certification in the clinical practice or medicine, psychiatry, psychology or behavior analysis.

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

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 is 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, a Physician assistant who has been authorized by a Physician to prescribe those services, or an advanced practice nurse with a collaborating agreement with a Physician that delegates that authority. This program includes physical, occupational and speech therapists, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service or Custodial Care Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

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

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

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

COURSE OF TREATMENT...means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE...means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE…means a service and supply specified in this benefit booklet for which benefits will be provided.

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

(i) A group health plan.

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

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

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

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

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

(vii) A State health benefits risk pool.

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

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

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

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

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

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-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans and positron emission tomography (PET) scans.

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

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

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

DURABLE MEDICAL EQUIPMENT PROVIDER…means a duly licensed durable medical equipment provider, 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 the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator 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 the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, the following amount:

(i) the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider's standard Claim Charges, and (b) an amount determined by the Claim Administrator to be approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider's standard Claim Charges and (b) an amount determined by the Claim Administrator to be 100% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the Eligible Charge cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 100% of the Provider's standard Claim Charges (unless otherwise required by applicable law or arrangement with the Non-Participating Provider), provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to you.

The Claim Administrator will utilize the same Claim processing rules, edits or methodologies that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the non-contracting Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits, rules or methodologies, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The non-contracting Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not

directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Eligible Charge amount does not equate to the Non-Participating Provider's Claim Charge, you will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON…means an employee or retired former employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY section of this benefit booklet.

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

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

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

(ii) serious impairment to bodily functions; or

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

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

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION...means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorders condition 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.

EMPLOYER…means the district with which you are employed or from which you retired.

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

EXPERIMENTAL/INVESTIGATIONAL or 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, mental health treatment, Substance Use Disorder Treatment or dental treatment.

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

- 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 Facility Other Provider in which they were performed; and

- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-fixed 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, the Claim Administrator still may determine such services or supplies to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational.

Approval by a government or regulatory agency will be taken into consideration in assessing Experimental/ Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

FAMILY COVERAGE...means coverage for you and your eligible dependents under the Health Care Plan.

HABILITATIVE SERVICES...means Occupational Therapy, Physical Therapy, Speech Therapy, and other health care services that help an eligible person keep, learn or improve skills and functioning for daily living, as prescribed by a Physician pursuant to a treatment plan. Examples include therapy for a child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for an eligible person with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this benefit booklet.

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 the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator 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 the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

A "Non-Participating Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits 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 Option 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 facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

IATROGENIC INFERTILITY…means an impairment of fertility by Surgery, radiation, Chemotherapy, or other medical treatment affecting reproductive organs or processes.

INDIVIDUAL COVERAGE...means coverage under the Health Care Plan 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 attain or maintain a viable pregnancy or 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.

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

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

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 has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator 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 Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service, or the reimbursement amount set by the Claim Administrator or the Host Blue Plan for Providers designated as Participating Professional Providers for a particular Covered Service. All benefit payments for Covered Services rendered by a Participating Professional Provider will be based on the Schedule of Maximum Allowances which such Provider has agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with Non-Participating Providers):

(i) the Provider's Claim Charge, or;

(ii) the Claim Administrator's non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim. Notwithstanding the preceding sentence, (1) the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Providers standard Claim Charge for such Covered Services, (2) the non- contracting Maximum Allowance for Ambulance Transportation services provided by Providers (other than Providers that bill through a Participating Provider, which use "Eligible Charge") will be such provider's Billed Charge, as described in the definition of Ambulance Transportation Eligible Charge, and (3) the non-contracting Maximum Allowance for other unsolicited Providers will be the same as the Maximum Allowance described in (a) above.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined based on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 100% of the Claim Administrator's rate for such Covered Services according to its current Schedule of Maximum Allowances. If there is no rate according to the Schedule of Maximum Allowances, then the Maximum Allowance will be 25% of Claim Charges.

The Claim Administrator will utilize the same Claim processing rules, edits or methodologies that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the non-contracting Maximum Allowance for a particular Covered Service. In the event the Claim Administrator does not have any Claim edits, rules or methodologies, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such Claims. The non-contracting Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Maximum Allowance amount does not equate to the Non-Participating Professional Provider's Claim Charge, you will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MAY DIRECTLY OR INDIRECTLY CAUSE...means the likely possibility that treatment will cause a side effect of Infertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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

MEDICALLY NECESSARY...SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

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

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

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

MENTAL ILLNESS…means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

> "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) Eating disorder, including, but not limited to, anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorder published by the American Psychiatric Association.

NON-ADMINISTRATOR HOSPITAL…SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER…SEE DEFINITION OF PROVIDER.

NON-EMERGENCY FIXED-WING AMBULANCE TRANSPORTATION…means Ambulance Transportation on a fixed-wing airplane from a Hospital emergency department, other health care facility or Inpatient setting to an equivalent or higher level of acuity facility when transportation is not needed due to an emergency situation. Non-Emergency Fixed-Wing Ambulance Transportation may be considered Medically Necessary when you require acute Inpatient care and services are not available at the originating facility and commercial air transport or safe discharge cannot occur. Non-Emergency Fixed-Wing Ambulance transportation provided primarily for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this Health Care Plan.

NON-PARTICIPATING HOSPITAL…SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER…SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING 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 the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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 the Claim Administrator or another Blue Cross and/ or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Orthotic Provider" means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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 Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder 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 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 Prescriptions to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he/she practices.

PHYSICAL THERAPIST...means a duly licensed physical therapist operating within the scope of 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.

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 Behavioral Health Unit for a determination of Medically Necessary care under this benefit booklet.

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 the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Prosthetic Provider" means a Prosthetic Provider who does not have a written agreement with the Claim Administrator 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.

An "Administrator Provider" means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Provider" means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A "Participating Provider" means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A "Non-Participating Provider" means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A "Professional Provider" means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

A "Participating Prescription Drug Provider" means a Preferred or Non-Preferred Pharmacy, including but not limited to, an independent retail Pharmacy, chain or retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

A "Non-Participating Prescription Drug Provider" means a Pharmacy, including but not limited to, an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which (i) has not entered into a written agreement with the Claim Administrator or (ii) has not entered into a written agreement with an entity chosen by the Claim Administrator to administer its prescription drug program, for such Pharmacy to provide pharmaceutical services at the time Covered Services to participants in the benefit program at the time Covered Services are rendered.

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

PSYCHOLOGIST...means a Registered Clinical Psychologist operating within the scope of such 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:

(i) 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

(ii) 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.

QUALIFIED ABA PROVIDER...means a Provider operating within the scope of his/her license registration or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:

(i) Master's level, independently licensed Clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided, for services treating Autism Spectrum Disorder (ASD) symptoms, with or without applied behavior analysis (ABA) service techniques; or

(ii) Master's level Clinician whose professional credential is recognized and accepted by an appropriate agency of the United States (i.e. Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst-Doctoral (BCBA-D) to supervise and provide treatment planning, with ABA service techniques; or

(iii) Health Care Practitioner who is certified as a provider under the TRICARE military health system, if requesting to provide ABA services; or

(iv) Master's level Clinician with a specific professional credential or certification recognized by the state in which the clinician is located; or

1. Developmental Therapist with Certified Early Intervention Specialist credential or CEIS; or
2. If the Doctor of Medicine (MD) prescribes ABA, writes a MD order for services to be provided by a specific person.

For the para-professional/line therapist:

(i) Two years of college educated staff person with a Board Certified Assistant Behavior Analyst (BCABA) for the para-professional/ therapist; or

(ii) A bachelor level or high school graduate having obtained a GED, or a staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist; or

(iii) A person who is "certified as a provider under TRICARE military health system," if requesting to provide ABA services.

REGISTERED DIETICIAN...means a duly licensed clinical professional counselor operating within the scope of his or her license.

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

A "Participating Registered Surgical Assistant" means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Registered Surgical Assistant" means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield 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.

RESCISSION…means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

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

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

A "Participating Retail Health Clinic" means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Retail Health Clinic" means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield 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 benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

(ii) 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.

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.

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

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

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

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

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

STANDARD FERTILITY PRESERVATION SERVICES…means procedure based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society for Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

SUBSTANCE USE DISORDER...means a condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

SUBSTANCE USE DISORDER TREATMENT...means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs consisting primarily of counseling by individuals other than a Physician or Psychologist, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disabilities or learning disabilities, care in lieu of detention or correctional placement or family retreats.

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

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

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

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

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 jawbone 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 website at *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 out-come based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

ELIGIBILITY SECTION

EMPLOYEE ELIGIBILITY

An eligible Employee who works on average 20 or more Hours of Service per week (or such minimum Hours of Service per week as may be required by the Participating Employer) will be eligible to enroll for coverage once he/she completes any service waiting period designated by the Participating Employer from the date he or she completes at least one Hour of Service. Participation in the Plan will begin as determined by each Participating Employer following completion of the waiting period provided all required election and enrollment forms are properly submitted to the Participating Employer. A Retiree who immediately prior to retirement was considered an Employee and was covered under the Plan will also be considered an eligible Employee.

An Employee shall be classified as one of the following:

1. **Certified Personnel:** a person required to have a teaching certificate for the position of employment that the person holds with the Employer;
2. **Educational Support Personnel:** a person not required to have a teaching certificate for the position of employment that the person holds with the Employer; or
3. **Retiree:** a former Employee (either Certified Personnel or Educational Support Personnel) who retired from employment as an eligible Employee of the Employer, was covered by the Plan (or the prior plan of the Employer) at the time of retirement and has maintained continuous coverage under the Plan (or the prior plan of the Employer) since retirement. A retired person will only qualify for coverage as a Retiree under the Plan if the person is eligible for a pension benefit or a disability pension benefit from either the Illinois Municipal Retirement Fund (IMRF) or the Teachers Retirement System (TRS), as determined by IMRF or TRS.

You are not eligible to participate in the Plan if you are an independent contractor, or a person performing services pursuant to a contract under which you are designated an independent contractor, regardless of whether you might later be deemed a common law employee by a court or governmental agency.

Employee Eligibility During Approved Leave of Absence or Disability

An Employee who otherwise qualifies as an eligible Employee who is on an approved leave of absence under the leave policy of the Participating Employer will be considered an eligible Employee during the approved leave period up to a maximum of 12 months from the end of the month in which the Employee was last actively at work. Any period for which the Employee receives vacation pay or sick pay and any other period of paid or unpaid leave, including but not limited to FMLA leave and leave while receiving Workers' Compensation benefits, will be included in the maximum 12-month leave period. Except as otherwise provided in the following paragraph, after 12 months of approved leave the Employee may continue coverage only by electing COBRA coverage under the COBRA Continuation of Coverage section of the Plan. In this circumstance, the last day of the approved leave or the end of the first 12-month period, whichever occurs first, will be the first day of the COBRA continuation of coverage period.

If an Employee is certified as disabled by Social Security, IMRF or TRS before the end of a 12-month leave the Employee will not be required to elect COBRA coverage and will continue to be eligible as an Employee during an approved leave of absence that exceeds 12 months as long as the certified disability continues and the individual otherwise continues to qualify as an eligible Employee or until the individual qualifies for coverage as a Retiree.

For more information related to the eligibility provisions that would qualify or disqualify you for this Plan, please contact your Participating Employer.

DEPENDENT ELIGIBILITY

Your Dependent is eligible for participation in this Plan provided he/she is:

(i) Your Spouse.

(ii) Your Civil Union Partner (as determined under Illinois law).

(iii) Your Child from birth until the end of the month in which he/she attains age 26.

(iv) Your unmarried Child age 26 to 30 if the child is an Illinois resident and has been discharged from service in the active or reserve components of the U.S. Armed Forces or National Guard.

(v) Your Child age 26 or older, who is mentally or physically incapable of sustaining his or her own living, provided the child suffered such incapacity prior to the end of the month in which he/she attained age 26 or age 30. In this case your Child must be unmarried and primarily dependent upon you for support. The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity, within 31 days of the child's 26th or 30th birthday, as applicable, or within 31 days following your enrollment in the Plan in the case of a new Employee. Thereafter the Plan may require proof of incapacity at reasonable intervals.

(vi) A child for whom you are required to provide health coverage under a Qualified Medical Child Support Order (QMCSO).

These terms have the following meanings:

"Child" means your natural born child, stepchild, legally adopted child (or a child placed with you in anticipation of adoption), Eligible Foster Child or a child for whom you are the Legal Guardian. Coverage for an Eligible Foster Child or a child for whom you became Legal Guardian before the child reached age 18 will remain in effect as long as such child meets the age requirements of an eligible Dependent under the terms of the Plan, even after the child has attained age 18 (or any other applicable age of emancipation of minors) and is no longer considered to be in your legal custody. The term "Child" shall include the children of your spouse or Civil Union Partner.

"Child placed with you in anticipation of adoption" means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

"Civil Union Partner" means an individual of the same or opposite sex registered under or recognized by Illinois law as the Employee's civil union partner. A domestic partnership or civil union that was legally entered into under the laws of another state is also recognized by Illinois as a civil union. The Employee will be required to submit an affidavit of civil union or other documentation issued under the applicable state law to the Participating Employer. A civil union partner after the civil union with the Employee has legally terminated will not be considered an eligible Dependent. The Plan Administrator reserves the right to require such evidence as it deems necessary that a civil union satisfies the above eligibility requirements.

"Eligible Foster Child" shall mean an individual who is placed with you by an authorized placement agency.

"Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

"Spouse" means any person who is lawfully married to you under any state law, including a person of the same sex if you are legally married. The Plan Administrator may require documentation proving a legal marital relationship.

The Plan Administrator, in its sole discretion, shall have the right to require documentation necessary to establish any individual's status as an eligible Dependent.

Excluded as Dependents are:

1. a spouse legally separated or divorced from the Employee;
2. a civil union partner after the civil union with the Employee has legally terminated; and
3. any child, spouse or civil union partner while on active duty in any military service of any country.

Each Participating Employer is responsible for verifying that its Employees, Retirees and their Dependents satisfy the eligibility requirements to participate in the Plan. The Employer may be required to submit evidence of eligibility to the Enrollment Administrator at any time.

When You and Your Spouse are both Covered Employees

If both an Employee and the Employee's Spouse or civil union partner are Employees of Employers participating in the Trust, each Spouse or partner may have separate coverage as an Employee. Either Spouse or partner may be covered as a Dependent of the other, or one or both may be covered as both an Employee and as a Dependent. An Employee may change from coverage as an Employee to coverage as a Dependent of his or her Spouse or partner, or from coverage as a Dependent to coverage as an Employee at any time, provided that there is not a lapse in coverage.

If an Employee or Spouse or partner is covered as both an Employee and as a Dependent, this Plan will coordinate benefits following the guidelines as described in the "Coordination of Benefits" section of the Plan.

Children may not be covered as Dependents of more than one Employee (or Retiree). A child may be covered under this Plan by only one Employee (or Retiree).

RETIREE ELIGIBILITY

A former Employee is eligible for Retiree coverage if the individual:

1. Is a retired former Employee of a Participating Employer;
2. Immediately prior to retirement, was considered an Employee and was covered under the Plan (or the prior plan of the Employer) and has maintained continuous coverage since retirement; and
3. Is eligible for a pension benefit or disability pension benefit from either the Illinois Municipal Retirement fund (IMRF) or the Teachers Retirement System (TRS), as determined by IMRF or TRS.

A Retiree's Spouse or Civil Union Partner and dependent children may continue coverage under the Retiree if they were covered under the Plan at the time the Employee retired and the Retiree timely elects to enroll them.

Retirees and their eligible Dependents are not permitted to enroll in the Plan after retirement. A covered Retiree is not permitted to enroll new Dependents acquired after retirement.

If both a Retiree and the Retiree's Spouse or Civil Union Partner are covered as Retirees (or as an Employee in the case of the Spouse or partner) of Employers participating in the Trust, each Spouse or partner may be covered as a Dependent of the other, or one or both Spouses or partners may be covered as both a Retiree (or Employee) and as a Dependent. A Retiree may change from coverage as a Retiree to coverage as a Dependent, or from coverage as a Dependent back to coverage as a Retiree, provided that there is no lapse in coverage and provided further that the Employer from which the Retiree retired continues to participate in the Trust. A mere change in status without a lapse in coverage will not be considered as a late enrollment, which is not permitted for Retirees and Dependents of Retirees.

If you wish to continue coverage for yourself and your eligible Dependents when you retire you must enroll for Retiree coverage by completing all required enrollment forms and submitting them to your Employer within 31 days after your retirement date.

You are required to pay the cost of Retiree coverage for yourself and any eligible Dependents in accordance with the policies and procedures established by your Employer.

TIMELY ENROLLMENT

Once you have completed any applicable waiting period as designated by your Participating Employer, and you and your eligible Dependents are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to your Employer's Human Resources Department. You will have 31 days from the date you are first eligible to enroll for coverage. Coverage will become effective on the date you become eligible. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you fail to complete and submit the appropriate election and enrollment forms described above, you will not be eligible to enroll in the Plan until the next annual open enrollment period unless you experience a Special Enrollment Event or a Qualifying Change in Status.

If you enroll in the Plan you cannot drop coverage for yourself or any Dependent until the next annual open enrollment period unless you experience a Special Enrollment Event or a Qualifying Change in Status.

NOTE: If you transfer your employment from one Participating Employer to another Participating Employer, you must enroll with your new Employer within 31 days. Transfer of coverage in this case is not automatic. Also, because special rules apply in such cases, please contact your Employer's Human Resources Department or the Enrollment Administrator for additional information.

ANNUAL OPEN ENROLLMENT

The Plan has one open enrollment period each year. The open enrollment period is from August 1 through September 30 each year, with an effective date of September 1 or October 1, as determined by each Participating Employer. You may add or drop coverage for yourself or your Dependents during the open enrollment period.

The coverage elections you make for yourself and your Dependents during the open enrollment period will be irrevocable for the next 12 months unless you have a Special Enrollment Event or a Qualifying Change in Status, as described later in this benefit booklet. If you and/or your Dependents choose not to enroll in the Plan for the following year or when first eligible, you will not be permitted to enroll before the next open enrollment period unless you have a Special Enrollment Event or a Qualifying Change in Status. Conversely, if you elect coverage under the Plan, you may not drop your coverage before the next open enrollment period unless you have a Special Enrollment Event or a Qualifying Change in Status.

Retired Employees and Dependents must be covered by the Plan at the time the Employee retires. Retirees and their Dependents are not permitted to enroll in the Plan after retirement. A covered Retiree is not permitted to enroll new Dependents acquired after retirement. The Special Enrollment rules described below do not apply to Retirees.

Changing Plans

The Trust offers several benefit plan options with different Schedules of Benefits. Each Participating Employer will decide which plan option or options will be available to its Employees. An Employer may offer only one plan option or may offer up to 5 plan options at any time.

If your Employer offers more than one plan option, you must select and enroll in the plan option you want when you first enroll and during each open enrollment period. All covered family members must enroll in the same plan option. You cannot change between plan options outside of the open enrollment period, unless:

1. You have a Special Enrollment Event that allows you to add coverage for yourself or a Dependent during the year, or

2. Your Employer offers a new or different plan option as of January 1 of any year. In that case, Employees of your Employer will be permitted to enroll in or drop coverage for themselves and their eligible Dependents as of the January 1 effective date of the change in plan offerings.

SPECIAL ENROLLMENT EVENTS

The Plan provides special enrollment periods that allow Employees to enroll in the Plan mid-year, even if they declined enrollment during an initial or subsequent open enrollment period.

Loss of Other Coverage

If you declined enrollment for yourself or your Dependents because you and/ or your Dependents had other health coverage, you may enroll for coverage under this Plan for yourself and/or your Dependents if you lose the other health coverage and you satisfy the conditions stated below. You must make written application for special enrollment within 31 days of the date of losing the other health coverage. Only individuals who had coverage and lose coverage under the circumstances described below are eligible to enroll.

You may enroll during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan;
2. You (or a Dependent) are not currently enrolled under the Plan;
3. When enrollment was previously offered, you declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan; and
4. The other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An Employee who is already enrolled in the Plan may enroll in a different benefit plan option if a Dependent has a special enrollment right because the Dependent lost eligibility for other coverage.

You are not eligible for this special enrollment right if:

1. The other coverage was COBRA continuation coverage and you did not exhaust the maximum time available to you for that COBRA coverage; or
2. The other coverage was lost due to non-payment of any required premium contribution or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the Employee and/or Dependent(s) will be effective the day following the loss of other health coverage as long as you submitted the appropriate election and enrollment forms to your Employer within 31 days of the date of losing the other coverage.

Acquisition of a New Dependent

If you acquire a new Dependent as a result of marriage, civil union, birth, adoption, or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents during a special enrollment period if you satisfy the conditions below. You must make written application for special enrollment no later than 31 days after you acquire the new Dependent.

You may enroll yourself and/or your eligible Dependents during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan; and

2. The Employee has acquired a new Dependent through marriage, civil union, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied and you enroll timely, coverage for the Employee and Dependent(s) will be effective at 12:01 a.m.:

1. For a marriage, on the date of the marriage;
2. For domestic partnership or civil union, on the date of registration as a civil union;
3. For a birth, on the date of birth; or
4. For an adoption or placement for adoption, on the date of birth if you are awarded physical or legal custody of a newborn child within 10 days of the date of birth. Otherwise, coverage for an adopted child will be effective as of the date of adoption or placement for adoption.

In the case of a newborn child, the time for enrolling the newborn (but not other family members) is extended, as follow:

1. Full Family or Employee Plus Child(ren) Coverage: If you are already enrolled and paying for full family coverage (Employee plus Spouse or civil union partner and at least one child) or Employee Plus Child(ren) coverage (Employee plus at least one child) your newborn child will be covered under your family coverage or Employee Plus Child(ren) coverage from birth. There is no time limit on enrolling the child in this case, but you must enroll the child before claims for the child can be considered.
2. Single or Employee Plus Spouse Coverage: If you are enrolled for single coverage or Employee plus Spouse or civil union partner coverage, you must enroll your newborn child within 90 days of birth or adoption and pay the additional premium, retroactive to the date of birth, to add the child. If you do not enroll your newborn within 90 days after birth, you will not be permitted to enroll the child until the next annual open enrollment period, unless you have another Qualifying Change in Status or Special Enrollment Event.

While you are allowed more than 31 days to enroll a newborn child, to take advantage of these Special Enrollment Rights to enroll yourself or other Dependents due to the birth of a child, you must enroll yourself and/or the other Dependents within 31 days of the birth.

Medicaid and SCHIP Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled also have special enrollment rights under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (SCHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (SCHIP) and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If you submit the appropriate election and enrollment forms to your Employer within 60 days after coverage under Medicaid or SCHIP terminates or after you qualify for a premium assistance subsidy, coverage under the Plan will become effective on the day following the date your Medicaid or SCHIP coverage terminates or the date you qualify for the premium subsidy.

An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

QUALIFYING CHANGE IN STATUS AND SECTION 125 PLANS

The Plan is structured to allow Participating Employers to maintain Section 125 Plans and to be compatible with the Section 125 Regulations of the Internal Revenue Code. In some cases, however, the Plan may allow changes in circumstances that may not be permitted under the Employer's Section 125 Plan. It is the Employer's responsibility to determine whether a change is per- mitted under the Employer's Section 125 Plan, if applicable.

Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event or a Qualifying Change in Status. If a Qualifying Change in Status occurs you may make a new election under the Plan provided your new election is consistent with the Qualifying Change in Status. You must submit the appropriate election and enrollment forms to your Employer's Human Resources Department within 31 days after the Qualifying Change in Status along with written proof of the event, except when a longer notice period is permitted under the Special Enrollment Event rules in the preceding section.

A Qualifying Change in Status includes the following:

1. A change in your legal marital status, including divorce, legal separation, annulment or entering into a civil union.
2. The death of your Spouse, Dependent Child or civil union partner.
3. Termination of a civil union.
4. Termination or commencement of employment by you, your Spouse or civil union partner or your Dependent Child that results in the gain or loss of eligibility under this Plan or another employer-sponsored employee medical benefit plan, including a strike or lockout.
5. A reduction or increase in your hours of employment or those of your Spouse, civil union partner or your Dependent Child, including a switch from part-time to full-time or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under this Plan or another employer-sponsored employee medical benefit plan.
6. Your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan.
7. A change in the place of residence or work of you, your Spouse or civil union partner or Dependent Child.
8. The annual TRS insurance plan open enrollment periods for Retirees and their eligible Dependents.
9. Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse or civil union partner or your Dependent Child.
10. Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly.
11. A change due to you, your Spouse, civil union partner or your Dependent Child gaining coverage under another employer's plan.
12. Change in Cost of Coverage or New Plan Option. If the cost of coverage increases or decreases during a Plan Year, the Employer may, in accordance with plan terms, automatically change the Participant's contribution. If permitted by the Section 125 plan, when the change in cost is significant, the Participant may elect to increase his/her contribution or elect less costly coverage. When a new plan option is added, the Participant may change his/her election to the new option.
13. Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan maintained by the employer of your Spouse or civil union partner or Dependent Child) provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

14. Insurance Marketplace Annual Open Enrollment Periods. The insurance marketplace offers annual open enrollment periods for coverage effective January 1 each year. A Participant who elects to enroll for coverage through the insurance marketplace during the marketplace annual open enrollment period will be permitted to drop Plan coverage as of December 31. An Employee who was previously enrolled for coverage through the marketplace will be permitted to drop that coverage and enroll in this Plan effective January 1. The Employer will be responsible for confirming that the decision to enroll in or drop coverage through this Plan corresponds to the Participant's decision to drop or add coverage purchased through the marketplace.

15. Insurance Marketplace Special Enrollment Periods. If you have a mid- year special enrollment opportunity to enroll for coverage through the insurance marketplace you may cancel your coverage under this Plan, but only if you (and all Dependents whose coverage is being cancelled) enroll for health insurance through the marketplace (or other private health insurance) with an effective date no later than the next day after coverage under this Plan terminates. The Employer will be responsible for confirming that the decision to drop coverage through this Plan corresponds to enrollment in other insurance. The Employer may rely on a signed statement from you specifying the special enrollment event and confirming that all Participants whose coverage is being cancelled have enrolled in or will enroll in other health insurance coverage by the stated deadline. The Employer may also require additional documentation of the other coverage. If you pay for coverage through a Section 125 cafeteria plan you may not be able to change your election under the Section 125 plan unless you enroll in coverage through the marketplace. Enrollment in other health insurance generally will not qualify to make changes under a Section 125 plan.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 31 days after the Qualifying Change in Status, except where a longer election period is permitted under the Special Enrollment Event rules.

A Change in Status does not allow you to change to a different Plan option outside the annual open enrollment period, except as specified above in the Changing Plans section.

REINSTATEMENT AFTER LAPSE IN COVERAGE DUE TO FAMILY OR MEDICAL LEAVE OF ABSENCE

The Plan will at all times comply with the Family and Medical Leave Act (FMLA) and any applicable state family and medical leave law. During FMLA leave, an Employee may maintain coverage under the Plan on the same terms and conditions as coverage would have been provided if the Employee had continued in active employment during the leave period.

The normal rules that preclude mid-year enrollment are waived for any Employee and eligible Dependents who were previously covered under the Plan and elect to resume coverage following a brief lapse in coverage, provided that ALL of the following requirements are satisfied:

1. Coverage lapsed during a period the Employee was on an approved leave of absence from the Employer;
2. The reason for the leave is a reason that would qualify as family or medical leave under the FMLA (whether or not the Employee is actually entitled to leave under the FMLA); and
3. The lapse in coverage does not exceed the shorter of the actual period of leave taken by the Employee or 12 weeks (26 weeks for military care- giver leave).

Under the FMLA a leave of absence may be taken for any one of the following reasons:

1. the birth of a child of the Employee;
2. placement of a child with the Employee for adoption or foster care;
3. a serious health condition that makes the Employee unable to perform his or her job;

4. to permit the Employee to care for a spouse or civil union partner, a child or parent if the family member has a serious health condition;

5. "qualifying exigency leave" if the Employee's spouse or civil union partner, child or parent (i) is a retired member of the Armed Forces or Reserves or in the Reserves or National Guard and (ii) is on active duty or ordered to active duty in the U.S. Armed Forces in support of a contingency operation (as designated by the Secretary of Defense and stated in the service member's active duty orders) to permit the Employee to make childcare, legal or financial arrangements or for other activities prescribed in the FMLA regulations; or

6. "military caregiver leave" to permit the Employee to care for a spouse or civil union partner, child, parent or next of kin who is either (i) a current member of the Armed Forces or National Guard or Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness, or (ii) a veteran who is undergoing medical treatment, recuperation or therapy for a serious injury or illness that was incurred in the line of active duty or aggravated by service on active duty.

Each Participating Employer is responsible for administering the FMLA and/ or any state family and medical leave laws in compliance with all applicable requirements.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Employer shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Qualified Medical Child Support Order (QMCSO) if the Employer determines that the order meets the standards set forth below. If an eligible Employee is ordered to provide coverage for a Child but the Employee is not enrolled in the Plan, the Employer shall also enroll the Employee for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Employer determines that the order is a QMCSO.

"Alternate Recipient" means any Child of an eligible Employee who is recognized under a Medical Child Support Order as having a right to enroll in this Plan as the Employee's Dependent.

"Medical Child Support Order" means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to an Employee's Child or directs the Employee to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" means a notice that contains the following information:

1. Name of an issuing State child support enforcement agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan or eligible for enrollment;
3. Name and mailing address for each of the Alternate Recipients (i.e., the child or children or their designated representative or the name and address of a State or local office may be substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for

which a Participant or Dependent is entitled under this Plan. For such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Employee and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. Identifies either the specific type of coverage or all available group health coverage;
3. Informs the Plan Administrator that if the NMSN does not designate either specific types of coverage or all available coverage, the Administrator should assume that all are designated, and further informs the Plan Administrator that if the plan has multiple options and the Employee is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to eligible Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Employer shall, as soon as administratively possible:

1. Notify the Employee and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Employee and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Employer shall:

1. Notify the State agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
    a. Whether the child is covered under the Plan; and
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

TERMINATION OF COVERAGE

TERMINATION DATES OF EMPLOYEE COVERAGE

Coverage of any Employee under this Plan will terminate on the earliest to occur of the following dates:

1. The date the Plan terminates;
2. The date your Employer ceases to be a Participating Employer;
3. The last day of the month for which you last made a contribution if you fail to make a required contribution when due;
4. The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained under the Continuation of Coverage During Military Leave section;
5. The last day of the month in which you cease to be eligible for coverage under the Plan;
6. The date coverage or certain benefits are terminated for your particular class by modification of the Plan;
7. The last day of the month in which your employment with a Participating Employer ends, unless you are eligible and enroll for coverage as a Retiree;
8. The last day of the 12th full month following the month in which you were last actively at work if you are on an approved leave of absence which extends beyond 12 months and you have not been certified as disabled by Social Security, IMRF or TRS; or
9. The date you or your Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

TERMINATION DATES OF RETIREE COVERAGE

Coverage of any Retiree under the Plan will terminate on the earliest to occur of the following dates:

1. The date the Plan terminates or no longer provides Retiree coverage;
2. The date your former Employer ceases to be a Participating Employer;
3. The date you cease to qualify as a Retiree, unless you are eligible and re-enroll for coverage as an Employee;
4. The last day of the month for which you last made a contribution if you fail to make a required contribution when due;
5. The date of your death; or
6. The date you or your Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Retirees and their Dependents must be covered by the Plan at the time the Employee retires. Retirees and their Dependents are not permitted to enroll in the Plan after retirement. When a Retiree terminates Retiree coverage under this Plan, the Retiree is not allowed to re-enroll at a later date as a Retiree.

TERMINATION DATES OF DEPENDENT COVERAGE

Coverage for the covered Dependents of an Employee or Retiree will terminate on the earliest to occur of the following dates:

1. The date the Plan terminates;
2. The date the Plan discontinues coverage for Dependents or any class of Dependents;

3. The date the Employee's or Retiree's coverage under the Plan terminates for any reason except death;

4. The last day of the month for which the Employee or Dependent last made a contribution if any required contribution is not paid when due;

5. The date the Dependent spouse or civil union partner reports to active military service;

6. The last day of the month in which a Dependent spouse or civil union partner ceases to be a Dependent as defined by the Plan, including by reason of legal separation or divorce, or legal termination of a civil union;

7. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:

   a. Cessation of such inability;

   b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or

   c. Upon the Child's no longer being dependent on the Employee or Retiree for support;

8. The last day of the month in which a Dependent Child ceases to qualify as a Dependent of the Employee or Retiree;

9. The date the Employee or Retiree or Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

SURVIVING DEPENDENT COVERAGE

In the event of death of an Employee or Retiree, coverage may continue for the Spouse, civil union partner, and/or other eligible Dependents who were covered at the time of the death, provided the Employer of the decedent re- mains a Participating Employer in the Trust, until the earliest of the following:

1. The last day of the month in which such Spouse or civil union partner remarries or enters into a civil union;

2. The last day of the month for which the survivor last made a contribution if any required contribution is not paid when due;

3. The date a surviving Dependent child becomes eligible for Medicare;

4. The last day of the month in which a surviving Dependent child ceases to satisfy the eligibility requirements for Dependent coverage under the Plan.

Eligible surviving Dependents who wish to continue coverage under the Plan beyond the end of the month in which the death occurred must enroll by completing all required election and enrollment forms and submitting them to the Employer's Human Resources Department within 31 days after the date of the Employee's/Retiree's death. Participation in the Plan will continue for the surviving Dependents as of the date of the death, provided all required election and enrollment forms are properly submitted to the Human Resources Department. The cost of Plan coverage under this survivor benefit will be communicated to the survivors by the Employer.

CONTINUATION OF COVERAGE

When coverage terminates under the provisions of the section, an individual may nevertheless be eligible to continue coverage under the circumstances described in the Continuation of Coverage section of the Plan.

RETROACTIVE TERMINATION OF COVERAGE

Except in cases where you and/or your covered Dependents fail to pay any required contribution for the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission

that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

SUSPENSION OF CLAIMS AFTER EMPLOYER WITHDRAWAL

If coverage terminates due to the withdrawal of your Employer as a Participating Employer in the Plan, and if your Employer fails to make all required contributions and withdrawal payments to the Trust, your claims must be suspended and payment will not be made until your Employer has satisfied its obligations to the Plan and Trust. If your Employer fails to satisfy its obligation to the Trust, the Employer will be responsible for any pending claims you or your Dependents may have.

UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of the following Covered Services **before** maximum benefits for such services are available:

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

Preauthorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Services designated by the Claim Administrator in order to be eligible for maximum benefits.

For Inpatient Hospital facility services, your Participating Provider is required to obtain Preauthorization. If Preauthorization is not obtained, the Participating Provider will be sanctioned based on the Claim Administrator's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about prior authorization for services outside of the Claim Administrator's service area, see the section of this benefit booklet entitled BlueCard Program in the GENERAL PROVISIONS section.

Failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator, as described in this section, may result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles and out-of-pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator. We encourage you to call ahead. The pre-notification toll-free telephone number is on your 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 Treatment. The utilization review provisions for the treatment of Mental Illness and Substance Use Disorder Treatment are specified in the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

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

  Whenever a non-emergency or non-maternity Inpatient Hospital admission is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may 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 the Health Care Plan.

  In the event of an emergency admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred.

- **Pregnancy/Maternity Admission Review**

  Pregnancy/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 Health Care Plan.

  In the event of a maternity admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred.

  Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

- **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 the Health Care Plan.

  Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **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 the Health Care Plan.

  Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **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 the Health Care Plan.

  Whenever Private Duty Nursing Service is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

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 the Health Care Plan.

Whenever the following Outpatient procedure(s)/services(s), are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Coordinated Home Care Program services
- Home hemodialysis
- Home Hospice
- Home Infusion Therapy
- All home health services
- Outpatient Infusion Drugs
- Private Duty Nursing
- Transplant evaluations
- Radiation therapy
- Chemotherapy

Cardiac (Heart related):

- Lipid Apheresis

Ears, Nose and Throat (ENT):

- Bone Conduction Hearing Aids
- Cochlear Implant
- Nasal and Sinus Surgery

Gastroenterology (Stomach):

- Gastric Electrical Stimulation (GES)

Neurological:

- Deep Brain Stimulation
- Sacral Nerve Neuromodulation/Stimulation
- Vagus Nerve Stimulation (VNS)

Orthopedic (Musculoskeletal):

- Artificial Intervertebral Disc
- Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions

- Femoroacetabular impingement (FAI) Syndrome
- Functional Neuromuscular Electrical Stimulation (FNMES)
- Lumbar Spinal Fusion
- Meniscal Allografts and other Meniscal Implants
- Orthopedic Applications of Stem-Cell Therapy

Pain Management:

- Occipital Nerve Stimulation
- Surgical Deactivation of Headache Trigger Sites
- Percutaneous and Implanted Nerve Stimulation and Neuromodulation
- Spinal Cord Stimulation

Surgical Procedures:

- Orthognathic Surgery; Face reconstruction
- Mastopexy; Breast lift
- Reduction Mammoplasty, Breast Reduction

Wound Care:

- Hyperbaric Oxygen (HBO2) Therapy

Specialty Pharmacy:

- Medical Benefit Specialty Drugs (Specialty drugs administered by your Provider)

Non-Emergency Fixed-Wing Ambulance Transportation:

- Please refer to the definition of "Non-Emergency Fixed-Wing Ambulance Transportation" in the DEFINITIONS section of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Whenever the following Outpatient services(s), received from a Non-Participating Provider, are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Dialysis
- Elective Surgery

If an Inpatient Emergency Hospital admission occurs after an Outpatient service, in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Claim Administrator.

For specific details about the Preauthorization requirement for any of the above referenced Outpatient services, please call the customer service number on the back of your identification card. The Claim Administrator reserves the right to no longer require Preauthorization during your benefit period for any or all of the listed services. Updates to the list of services requiring Preauthorization may be confirmed by calling the customer service number.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator 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 the Health Care Plan.

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 the Health Care Plan.

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 the Health Care Plan.

Upon completion of the preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

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 authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS—WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

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

Remember that the Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be 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, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

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.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your identification card. Your Physician should use the contact information in the notification letter.

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, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Blue Cross and Blue Shield of Illinois
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under this Health Care Plan.

CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

The Claim Administrator's Behavioral Health Unit has been established to assist in the administration of Mental Illness and Substance Use Disorder Treatment benefits, including Preauthorization review, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for your Inpatient Hospital admissions and/or Outpatient services for the treatment of Mental Illness and Substance Use Disorders.

Failure to contact the Behavioral Health Unit or to comply with the determinations of the Behavioral Health Unit, as described in this section, may result in a reduction of benefits. The Behavioral 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.

Preauthorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Services designated by the Claim Administrator in order to be eligible for maximum benefits.

For Inpatient Hospital facility services, your Participating Provider is required to obtain Preauthorization. If Preauthorization is not obtained, the Participating Provider will be sanctioned based on the Claim Administrator's contractual agreement with the Provider, and the member will be held harm-less for the Provider sanction. For additional information about prior authorization for services outside of the Claim Administrator's service area, see the section of this benefit booklet entitled BlueCard Program in the GENERAL PROVISIONS section.

Failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator, as described in this section, may result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles and out-of-pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator. We encourage you to call ahead. The pre-notification toll-free telephone number is on your identification card.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

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

  In order to receive maximum benefits under this Health Care Plan, you must Preauthorize for your nonemergency Inpatient Hospital admission for the treatment of Mental Illness (other than Substance Use Disorder Treatments described below) by calling the Behavioral Health Unit.

  Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied, as described in this section. To determine if the Provider has completed the Preauthorization requirements, you or someone on your behalf may call customer service at the toll-free number on your identification card. This call must be made at least one day prior to the Inpatient Hospital admission.

  Your Participating Provider, and not you, is required to obtain Preauthorization for Inpatient Hospital admissions for Substance Use Disorder Treatment.

  For all other Non-Participating Providers, the Provider must notify the Claim Administrator within two business days after the initiation of Inpatient Hospital admissions for Substance Use Disorder Treatment, to the extent required by law. If your Provider does not notify the Claim Administrator, then you or someone on your behalf must notify the Claim Administrator within three business days of the initiation of Substance Use Disorder Treatment.

- **Residential Treatment Center Preauthorization Review**

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

  Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness (other than Substance Use Disorder Treatments described below) is recommended by your Physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Behavioral Health Unit. This call must be made at least one day prior to scheduling of the admission. Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied, as described in this section. To determine if the Provider has completed the Preauthorization requirements, you or someone on your behalf may call customer service at the toll-free number on your identification card. This call must be made at least one day prior to the Inpatient Hospital admission.

  Your Participating Provider, and not you, is required to obtain Preauthorization for Residential Treatment Center admissions for Substance Use Disorder Treatment.

  For all other Non-Participating Providers, the Provider must notify the Claim Administrator within two business days after the initiation of Residential Treatment Center admissions for Substance Use Disorder Treatment, to the extent required by law. If your Provider does not notify the Claim Administrator, then you or someone on your behalf must notify the Claim Administrator within three business days of the initiation of Substance Use Disorder Treatment.

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

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

  In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Behavioral Health Unit no later than two business days after the admission for the treatment of Mental Illness (other than Substance Use Disorder Treatments described below) has occurred.

  Your Participating Provider, and not you, is required to obtain Preauthorization for Inpatient Hospital admissions for Substance Use Disorder Treatment.

  For all other Non-Participating Providers, the Provider must notify the Claim Administrator within two business days after the initiation of Inpatient Hospital admissions for Substance Use Disorder Treatment, to the extent required by law. If your Provider does not notify the Claim Administrator, then you or someone on your behalf must notify the Claim Administrator within three business days of the initiation of Substance Use Disorder Treatment.

  If the call is made any later than the specified time period, you may not be eligible for maximum benefits. Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied, as described in this section. To determine if the Provider has completed the Preauthorization requirements, you or someone on your behalf may call customer service at the toll-free number on your identification card.

- **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 the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must notify the Behavioral Health Unit no later than 48 hours after the admission for the treatment of Mental Illness (other than Substance Use Disorder Treatments described below) has occurred. Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied, as described in this section. To determine if the Provider has completed the Preauthorization requirements, you or someone on your behalf may call customer service at the toll-free number on your identification card. The Behavioral Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

Your Participating Provider, and not you, is required to obtain Preauthorization for Partial Hospitalization Treatment Programs for Substance Use Disorder Treatment.

For all other Non-Participating Providers, the Provider must notify the Claim Administrator within two business days after the initiation of Partial Hospitalization Treatment Programs for Substance Use Disorder Treatment, to the extent required by law. If your Provider does not notify the Claim Administrator, then you or someone on your behalf must notify the Claim Administrator within three business days of the initiation of Substance Use Disorder Treatment.

If an Inpatient Emergency Mental Illness Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Behavioral Health Unit for an Emergency Mental Illness Admission Review.

- **Length of Stay/Service Review**

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

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

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Behavioral Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Behavioral Health Unit Physician for review except as otherwise described in the APPEAL PROCEDURE section of this benefit booklet.

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 the Health Care Plan.

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

  - Psychological testing
  - Neuropsychological testing
  - Electroconvulsive therapy

- Intensive Outpatient Programs. (Please note, if your Provider of Substance Use Disorder Treatment notifies the Claim Administrator within two business days of the initiation of the service, you will not be required to Preauthorize.)

- Repetitive Transcranial Magnetic Stimulation

- Applied Behavior Analysis (ABA) Therapies (Please see coverage details as described in the Autism Spectrum Disorder (s) provision under the SPECIAL CONDITIONS AND PAYMENT section of this benefit booklet.).

Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the scheduling of the planned Outpatient services(s). The Behavioral 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 Health Care Plan, an additional call must be made to the Behavioral Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission, Outpatient service, or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Behavioral Health Unit. If the Behavioral Health Unit concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, benefit for some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determinations, 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 Behavioral 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 described in this benefit booklet, see the provision entitled "EXCLUSIONS—WHAT IS NOT COVERED."

The Behavioral 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 Behavioral 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 is Medically Necessary under the Health Care Plan.

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

Remember that your Health Care Plan 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, the Claim Administrator will not pay for the hospitalization, services or supplies if the Behavioral Health Unit decides

they were not Medically Necessary, except as otherwise provided in the APPEAL PROCEDURE section of this benefit booklet.

BEHAVIORAL HEALTH UNIT PROCEDURE

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

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

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

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review;
3. 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 disagrees with the determinations of the Behavioral Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Behavioral Health Unit and requesting an expedited appeal. The Behavioral Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Behavioral Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Behavioral Health Unit Physician, you may request an appeal in writing as outlined below.

If the Claim Administrator determines that Benefits, as defined below, related to Substance Use Disorder Treatment are no longer Medically Necessary, you or your authorized representative shall be notified in writing within 24 hours of the Adverse Determination of your right to request an external review. Because the denial was based on a medical judgment, you may have the right to an Independent External Review as described in INDEPENDENT EXTERNAL REVIEW provisions in the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet.

You or your authorized representative may only request an expedited external review if initiated as described in the EXPEDITED EXTERNAL REVIEW provision in the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet, within 24 hours following the Adverse Determination notification from the Claim Administrator for Benefits related to Substance Use Disorder Treatment. Failure to request an expedited external review within 24 hours shall preclude you or your authorized representative from requesting an expedited external review. An expedited external review may not occur if the Substance Use Disorder Treatment Provider or facility determines that continued treatment is no longer Medically Necessary. For purposes of this section, "Benefits" means the benefits provided for treatment services for Inpatient and Outpatient treatment of Substance Use Disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (Partial

Hospitalization), 3.1 (Clinically Managed Low-Intensity Residential), 3.3 (Clinically Managed Population-Specific High-Intensity Residential), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services.

If an expedited external review request meets the criteria of the Health Carrier External Review Act, an independent review organization (IRO) shall make a final determination of Medical Necessity within 72 hours of the receipt of the request by the Claim Administrator. If an IRO upholds an Adverse Determination, the Claim Administrator will provide coverage of Benefits through the day following the determination of the IRO.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Behavioral 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, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

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

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

Additional information about appeals procedures is set forth in the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO PREAUTHORIZE OR NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Behavioral Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Behavioral Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

For Outpatient behavioral health services, there is no penalty to you for failure to notify the Claim Administrator. For Substance Use Disorder Treatment, there is no penalty to you for failure to notify the Claim Administrator for Inpatient Hospital admissions, Residential Treatment Centers and Partial Hospitalization Treatment Programs.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Health Care Plan.

CASE MANAGEMENT

You may call the Behavioral Health Unit at the number shown on your identification card to access a case manager. They may answer questions about your behavioral condition, help you understand what to expect when you are discharged from a behavioral health facility to your home or to another care facility and help coordinate special care you may need. The behavioral health case management program is designed to help those with mental health and/or substance use concerns manage the unique challenges of those conditions. A case manager may reach out to you via phone or letter to offer case management assistance.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

You can visit the Blue Cross and Blue Shield of Illinois Website at *www.bcbsil.com* for a directory of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator 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 Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

YOUR BENEFIT PERIOD

Your benefit period is the calendar year. When you first enroll under this coverage, your first benefit period begins on the effective date of your coverage and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each calendar year you must satisfy the deductible amount before benefits begin for most Covered Services. The calendar year deductible is sometimes referred to as the program deductible in this benefit booklet. A separate calendar year deductible applies for Covered Services rendered by Participating Provider(s) (the Network deductible) and for Covered Services rendered by Non-Participating Provider(s) and Non-Administrator Provider(s) (the Non-Network deductible). The Network and Non-Network calendar year deductibles are stated in the Schedule of Benefits for your plan of benefits.

Note: Benefits for some preventive and wellness Covered Services will begin even if you have not met the calendar year deductible. In addition, in some plans other Covered Services, including prescription drugs, emergency room services and physician office visits with Participating Providers, may be covered before you meet the calendar year deductible. Please review the Schedule of Benefits for your plan of benefits.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the family Network deductible amount for Covered Services rendered by Participating Provider(s), and the separate Non-Network deductible for Covered Services rendered by Non-Participating Provider(s) and Non-Administrator Provider(s), as shown in your Schedule of Benefits, it will not be necessary for anyone else in your family to meet the applicable deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the deductible before receiving benefits. A family member may not apply more than the individual deductible amount toward the family deductible.

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 deductible will be applied against those Covered Services.

INPATIENT HOSPITAL ADMISSION COPAYMENT

This Copayment applies only if you are enrolled in Plan A, Plan B, Plan C, Plan E1, Plan AB1, Plan M6, Plan M7 or Plan M8.

In these plans, in addition to the calendar year deductible, you must pay a Copayment each time you are admitted to a Hospital, up to a maximum of three (3) such Copayments per person in one benefit period. The Network Hospital admission Copayment applies when you are admitted to a Participating Hospital and the Non-Network Copayment applies when you are admitted to a Non-Participating Hospital or Non-Administrator Hospital. The Network and Non-Network Inpatient Hospital admission Copayments are stated in the Schedule of Benefits for your plan of benefits.

In these plans the same Copayments apply for Outpatient surgical procedures at Outpatient Hospital facilities or Ambulatory Surgical Facilities. You will not pay more than three (3) of these Copayments per person in one benefit period, including all Copayments for Inpatient Hospital admissions and Outpatient surgical procedures.

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 benefit booklet 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 described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet 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.

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

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Benefits received for two days of partial hospitalization will equal the benefits for one full day of Inpatient Hospital care.

Coordinated Home Care

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

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at the Network percentage of the Eligible Charge shown in the Schedule of Benefits for your plan of benefits after you have met your program deductible and, if applicable to your plan of benefits, the Inpatient Hospital admission Copayment, unless otherwise specified in this benefit booklet. 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.

Benefits for preadmission testing by a Participating Provider will be provided at 100% of the Eligible Charge. Benefits for preadmission testing will not be subject to the program deductible.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at the Non-Network percentage of the Eligible Charge shown in the Schedule of Benefits for your plan of benefits after you have met your program deductible and, if applicable to your plan of benefits, your Inpatient Hospital admission Copayment. 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.

Benefits for preadmission testing by a Non-Participating Provider will be provided at the Non-Network percentage of the Eligible Charge shown in your Schedule of Benefits. Benefits for preadmission testing will not be subject to the program deductible.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received from a Non-Participating Provider.

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

11. 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

Participating Provider

Benefits will be provided at the Network percentage of the Eligible Charge shown in the Schedule of Benefits for your plan of benefits, after you have met your program deductible, when you receive Outpatient Hospital Covered Services from a Participating Provider.

Outpatient Surgical Copayment if you are enrolled in Plan A, Plan B, Plan C, Plan E1, Plan AB1, Plan M6, Plan M7 or Plan M8: Benefits for Outpatient Surgery will be provided at the Network percentage of the Eligible Charge after you pay the program deductible and the Outpatient Surgical Copayment shown in your Schedule of Benefits. However, you will not pay more than three (3) of these Copayments per person in one benefit period, including all Copayments paid for Inpatient Hospital admissions and Outpatient Surgery.

Urgent Care Facility Copayment. Benefits for urgent care from a Participating Provider will be provided at the Network percentage of the Hospital's Eligible Charge after you pay the urgent care facility Copayment shown in the Schedule of Benefits for your plan of benefits. Your program deductible will not apply to the facility charge.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at the Non-Network percentage of the Eligible Charge shown in the Schedule of Benefits for your plan of benefits after you have met your program deductible.

Outpatient Surgical Copayment if you are enrolled in Plan A, Plan B, Plan C, Plan E1, Plan AB1, Plan M6, Plan M7 or Plan M8. Benefits for Outpatient Surgery will be provided at the Non-Network percentage of the Eligible Charge after you pay the program deductible and the Outpatient Surgical Copayment shown in your Schedule of Benefits. However, you will not pay more than three (3) of these Copayments per person in one benefit period, including all Copayments paid for Inpatient Hospital admission and Outpatient Surgery.

Urgent Care Facility Copayment. Benefits for urgent care from a Non-Participating Provider will be provided at the applicable percentage of the Hospital's Eligible Charge after you pay the urgent care facility Copayment shown in the Schedule of Benefits for your plan of benefits. Your program deductible will not apply to the facility charge.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at the percentage of the Eligible Charge stated in your Schedule of Benefits when you receive Covered Services that meet the definition of Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

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

Benefits for Emergency Medical Care will be provided at the percentage of the Eligible Charge stated in your Schedule of Benefits when you receive Covered Services that meet the definition of Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

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

Emergency Room Copayment. Each time you receive Covered Services in an emergency room, you will be responsible for the emergency room Copayment stated in your Schedule of Benefits. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

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

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Eligible Charge for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or

2. the amount for the emergency care service calculated using the same method the Participating Providers generally use to determine payments for Non-Participating Provider services but substituting the Participating cost-sharing provisions for the Non-Participating Provider cost-sharing provisions; or

3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

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

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet 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 described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet 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 Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

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

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

3. 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.

4. Dental Care—Expenses for any care or treatment of teeth, gums or alveolar process will not be considered eligible unless such expenses are for:

    - Reduction of fractures of the jaw or facial bones;
    - Surgical correction of harelip, cleft palate or protruding mandible;
    - Removal of stones from salivary ducts;
    - Bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues;
    - Freeing of muscle attachments;
    - Hospital Outpatient or Inpatient charges in connection with oral Surgery, extractions or other non-cosmetic dental procedures, but only if treatment in a Hospital setting is Medically Necessary for the patient's condition (this includes only Hospital facility charges and does not include charges of a Dentist or oral surgeon for non-covered dental procedures, anesthesia or other charges);
    - Emergency medical services related to an injury to sound, natural teeth.

5. Cataract Surgery and initial placement of one pair of eyeglasses, contact lenses, or intraocular lens following cataract Surgery.

6. Lenses, initial pair of eyeglasses, contact lenses or an intraocular lens following Medically Necessary Surgery to the eye for aphakic patients. Benefits will also be provided for soft lenses or sclera shells intended for use as corneal bandages.

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.

   Benefits will be provided for anesthesia administered in connection with covered dental care treatment rendered in a dental office, oral surgeon's office, Hospital or Ambulatory Surgical Facility if you are under age 19 and have been diagnosed with an autism spectrum disorder or a developmental disability.

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

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

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

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

   - It manifested before the age of 22;

   - It is likely to continue indefinitely; and

   - It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.

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 voluntary).

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 from a Participating Provider 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 Skilled Nursing Facility, or Substance Use Disorder Treatment Facility or a Residential Treatment Center or

2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or

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

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your 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 also be provided for education programs that allow you to maintain a hemoglobin A1c level within the ranges identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management, operating within the scope of his/her license. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

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

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

Emergency Accident Care

Emergency Medical Care

Electroconvulsive Therapy

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. Benefits for Outpatient Occupational Therapy normally will be limited to a maximum of 20 visits per benefit period. Additional visits may be provided, subject to Medical Necessity.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a licensed professional Physical Therapist; provided, however, when the therapy is beyond the scope of the Physical Therapist's license, the Physical Therapist must be under the supervision of a Physician, and 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 or similar illness, subject to the Outpatient Physical Therapy benefit maximum. Benefits for Outpatient Physical Therapy normally will be limited to a maximum of 20 visits per benefit period. Additional visits may be provided, subject to Medical Necessity.

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 the maximum dollar amount per benefit period shown in your Schedule of Benefits.

Radiation Therapy Treatments

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. Outpatient Speech Therapy benefits normally will be limited to a maximum of 20 visits per benefit period. Additional visits may be provided, subject to Medical Necessity.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

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

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

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.

Acupuncture—Benefits will be provided for acupuncture when rendered by a Physician or a licensed Acupuncturist.

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.

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 benefit booklet.

Orthotic Devices

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

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

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).

Routine Pediatric Hearing Examination—Benefits will be provided for routine pediatric hearing examinations.

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.

Tobacco Cessation Drugs

Growth Hormone Therapy

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

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 Network percentage of the Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

When you receive Covered Services in a Participating Provider's office, benefits for office visits are subject to the Copayment shown in the Schedule of Benefits for your plan of benefits. After the applicable Copayment, benefits for office visits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

Different Physician office visit Copayments apply for visits with specialist Physicians and with primary care Physicians. For this purpose, a specialist is a Professional Provider who is **not** a Physician in general practice, family practice, internal medicine, obstetrics, gynecology or pediatrics, or a mental health Provider.

Benefits for Covered Services for diagnostic laboratory expenses from a Participating Provider independent laboratory will be provided at 100% of the Maximum Allowance and your program deductible will not apply.

When you receive Covered Services for urgent care from a Participating Provider physician, benefits will be provided at the percentage of the Maximum Allowance shown in your Schedule of Benefits after you have met your program deductible.

When you receive tobacco cessation drugs from a Participating Provider, benefits will be provided at 100% of the Maximum Allowance and your program deductible will not apply. Benefits will be provided for prescription or over-the-counter tobacco cessation drugs.

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at the Non-Network percentage of the Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, after you have met your program deductible.

When you receive Covered Services for urgent care from a Non-Participating Provider physician, benefits will be provided at the percentage of the Maximum Allowance shown in your Schedule of Benefits, after you have met your program deductible.

Chiropractic and Osteopathic Manipulation

Benefits for chiropractic and osteopathic manipulation will be provided at the percentage of the Maximum Allowance shown in your Schedule of Benefits, after you have met your program deductible, up to the maximum annual dollar benefit shown in your Schedule of Benefits.

Emergency Care

Benefits for Emergency Accident Care will be provided at the percentage of the Maximum Allowance shown in your Schedule of Benefits when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply.

When you receive Covered Services for Emergency Accident Care in a Provider's office, benefits for office visits are subject to an office visit Copayment. After the Copayment, benefits for office visits will be provided at 100% of the Maximum Allowance.

Benefits for Emergency Medical Care will be provided at the percentage of the Maximum Allowance shown in your Schedule of Benefits when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply.

When you receive Covered Services for Emergency Medical Care in a Provider's office, benefits for office visits are subject to an office visit Copayment. After the Copayment, benefits for office visits will be provided at 100% of the Maximum Allowance.

However, Covered Services for Emergency Accident Care and Emergency Medical Care 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.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Maximum Allowance for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or

2. the amount for the emergency care service calculated using the same method the Participating Providers generally use to determine payments for Non-Participating Provider services but substituting the Participating cost-sharing provisions for the Non-Participating Provider cost-sharing provisions; or

3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

Participating Providers are:

- Acupuncturists
- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors

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

who have signed an Agreement with the Claim Administrator 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 Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Acupuncturists
- 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 Dieticians
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's 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 Professional Provider or the Claim Administrator at the toll free number on your ID card.

OTHER COVERED SERVICES

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

- Blood–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.

- Wigs—Benefits will be provided for wigs (also known as cranial prosthesis) when your hair loss is due to Chemotherapy, radiation therapy or alopecia.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

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

Benefits for ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility) when received from a Provider will be provided at the percentage of the Eligible Charge or the percentage of the Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, after you have met your program deductible.

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

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

SPECIAL CONDITIONS AND PAYMENTS

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

HUMAN ORGAN TRANSPLANTS

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

- If both the donor and recipient have coverage each will have their benefits paid by their own program.

- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet 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 described in this benefit booklet 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 the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator 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 Claim Administrator approved Human Organ Transplant Program.

- 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 benefit booklet, 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 benefit booklet, 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.

BENEFIT PAYMENT FOR HUMAN ORGAN TRANSPLANTS

Participating Provider

When you receive Covered Services for human organ transplants from a Participating Provider, benefits will be provided at the percentage of the Eligible Charge or the percentage of the Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, and your program deductible will not apply.

Non-Participating Provider

Benefits for Covered Services for human organ transplants from a Non-Participating Provider **will not be provided**.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator 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 transmyocardial revascularization.

BENEFIT VALUE ADVISOR

The Benefit Value Advisor (BVA) program has been established to assist you in maximizing your benefits under this benefit booklet. Benefit Value Advisors are trained customer service representatives who assist you by comparing cost and providing information on Participating Providers for certain types of health care services. A BVA helps you navigate your benefits.

In addition to calling the BVA, you may also have other call requirements. A call to the BVA does not satisfy any other call requirements you may have.

PREVENTIVE CARE SERVICES

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

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

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

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

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

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 in items 1. through 4. above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Claim Administrator's website at *www.bcbsil.com* or contact customer service at the toll-free number on your identification card.

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

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

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

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

2. Alcohol misuse screening and counseling

3. Aspirin use for men and women for prevention of cardiovascular disease for 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. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease

9. HIV screening for all adults at higher risk

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

    - Hepatitis A
    - Hepatitis B

- Herpes Zoster (Shingles)
- Human papillomavirus
- Influenza (Flu shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

11. Obesity screening and counseling

12. Sexually transmitted infections (STI) counseling

13. Tobacco use screening and cessation interventions for tobacco users

14. Syphilis screening for adults at higher risk

15. Exercise interventions to prevent falls in adults age 65 years and older who are at increased risk for falls

16. Hepatitis C virus (HCV) screening for adults at increased risk, and one time for everyone born between 1945-1965

17. Hepatitis B virus screening for persons at high risk for infection

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

19. Lung cancer screening in adults 55 and older who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years

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

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

22. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history of CVD, (b) one or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking) and (c) a calculated 10-year CVD risk of 10% or greater

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

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

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

2. BRCA counseling about genetic testing for women at higher risk

3. Breast cancer chemoprevention counseling for women at higher risk

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

5. Cervical cancer screening

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

7. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs

8. Domestic and interpersonal violence screening and counseling for all women

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

10. Diabetes mellitus screening after pregnancy

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

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

14. HIV screening and counseling for 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 65, and younger women with 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 women

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

21. Well-woman visits to obtain recommended preventive services

22. Urinary incontinence screening

23. Breast cancer mammography screening, including breast tomosynthesis and, if Medically Necessary, a screening MRI

24. Aspirin use for pregnant women to prevent preeclampsia

25. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

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

1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Critical congenital heart defect screening for newborns
7. Major depression disorder ("MDD") screening for adolescents
8. Development screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children ages 9-11 and 17-21
10. Bilirubin screening in newborns
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns, children and adolescents
15. Height, weight and body mass index measurements
16. Hematocrit or hemoglobin screening
17. Hemoglobinopathies or sickle cell screening for all newborns
18. HIV screening for adolescents at higher risk
19. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Human papillomavirus
    - Influenza (Flu shot)
    - Measles, Mumps, Rubella
    - Meningococcal

- Pneumococcal
- Varicella
- Haemophilus influenzae type b
- Rotavirus
- Inactivated Poliovirus
- Diphtheria, tetanus and a cellular pertussis

20. Lead screening for children at risk for exposure
21. Medical history for all children throughout development
22. Obesity screening and counseling
23. Oral health risk assessment for younger children up to six years old
24. Phenylketonuria (PKU) screening for newborns
25. Sexually transmitted infections (STI) prevention and counseling for adolescents
26. Tuberculin testing for children at higher risk of tuberculosis
27. Vision screening for children and adolescents
28. Autism screening
29. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
30. Newborn blood screening
31. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

The FDA-approved contraceptive drugs and devices currently covered under this benefit provision are listed on the *Contraceptive Coverage List*. This list is available on the Claim Administrator's website at *www.bcbsil.com* and/or 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 Coverage List*. You may, however, have coverage under other sections of this benefit booklet, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The *Contraceptive Coverage List* and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

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 described in your Schedule of Benefits, if applicable.

Preventive care services received from a Non-Participating Provider, or a Non-Administrator 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 maximums.

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

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

WELLNESS CARE

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

- Routine diagnostic medical procedures;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray;
- Routine cologuard screening for colon cancer;
- Routine digital rectal examinations and prostate tests.

Participating Provider

When you receive Covered Services for wellness care from a Participating Provider, benefits for wellness care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Non-Participating Provider

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at the Non-Network percentage of the Eligible Charge or the Maximum Allowance shown in the Schedule of Benefits for your plan of benefits after you have met your program deductible.

However, the following vaccinations from a Non-Participating Provider will be provided at 100% of the Maximum Allowance, up to the maximum benefits shown below or as stated in your Schedule of Benefits:

- Influenza vaccine - $40 per benefit period.
- Pneumonia vaccine (per the guidelines outlined by the United States Preventive Services Task Force (USPSTF)) - $85 per benefit period.
- Zoster (Zostavax) for shingles (per the guidelines outlined by the USPSTF) - $200 per benefit period.
- Tetanus, Diphtheria and Toxoids (per the guidelines outlined by the USPSTF) - $40 per benefit period.
- Hepatitis A and Hepatitis B (per the guidelines outlined by the USP- STF) - $100 per benefit period.

- Combined Tetanus, Diphtheria and Pertussis (TDAP) (per the guidelines outlined by the USPSTF) - $55 per benefit period.

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 an Administrator Skilled Nursing Facility will be provided at the Network percentage of the Eligible Charge for Hospital benefits shown in the Schedule of Benefits for your plan of benefits, after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at the Non-Network percentage of the Eligible Charge for Hospital benefits shown in your Schedule of Benefits, 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 benefit booklet 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 an Administrator Ambulatory Surgical Facility will be provided at the Network percentage of the Eligible Charge for Outpatient Hospital benefits shown in the Schedule of Benefits for your plan of benefits. Benefits for services rendered by a Non-Administrator Ambulatory Surgical Facility will be provided at the Non-Network percentage of the Eligible Charge for Outpatient Hospital benefits shown in your Schedule of Benefits.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible, and, if applicable, the appropriate Outpatient Surgical Copayment shown in your Schedule of Benefits, up to a maximum of three (3) Inpatient Hospital admission and Outpatient Surgical Copayments in one benefit period.

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 (a) by a Physician or a Psychologist who has determined that such care is Medically Necessary, or (b) by a certified, registered or licensed health care professional with expertise in treating Autism Spectrum Disorder(s), including but not limited to, a health care professional who is eligible as a Qualified ABA Provider by state regulation and when such care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:

- 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.

Preauthorization will assess whether services meet coverage requirements. Review the OUTPATIENT SERVICE PREAUTHORIZATION REVIEW provisions in the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet for more specific information about Preauthorization.

HABILITATIVE SERVICES

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

- a physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
- treatment is administered by a licensed speech-language pathologist, audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, or Psychologist upon the referral of a Physician; and
- treatment must be Medically Necessary and therapeutic and not Investigational.

SUBSTANCE USE DISORDER TREATMENT

Benefits for all of the Covered Services previously described in this benefit booklet are available for Substance Use Disorder Treatment. In addition, benefits will be provided if these services are rendered by a Substance Use Disorder Treatment Facility. Benefits will be provided at the payment levels described later in this benefit booklet. Substance Use Disorder Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Administrator Provider facility payment level described later in this benefit section.

DETOXIFICATION

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

MENTAL ILLNESS SERVICES

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by the following Professional Provider(s) working within the scope of their license:

- Physician
- Psychologist
- Clinical Social Worker
- Clinical Professional Counselor
- Marriage and Family Therapist

Benefit Payment for Outpatient treatment of Mental Illness and Substance Use Disorder Treatment

Benefits for Outpatient Mental Illness treatment will be provided at the Network percentage of the Eligible Charge or Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, when you receive services from a Participating Provider after you have met your program deductible.

When you receive Covered Services from a Non-Participating Provider for Outpatient Mental Illness treatment, benefits will be provided at the Non-Network percentage of the Eligible Charge or Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, after you have met your program deductible.

Benefits for Outpatient Substance Use Disorder Treatment (in a program approved by the Claim Administrator) will be provided at the Network percentage of the Eligible Charge or Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, when you receive services from a Participating Provider, after you have met your program deductible.

When you receive Covered Services from a Non-Participating Provider for Outpatient Substance Use Disorder Treatment, benefits will be provided at the Non-Network percentage of the Eligible Charge or Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, after you have met your program deductible.

Office visits with Participating Professional Providers for Mental Illness or Substance Use Disorder Treatment will be subject to the Copayment for primary care (non-Specialist) Physicians shown in your Schedule of Benefits. The program deductible will not apply for Professional Provider office visits.

Benefit Maximum for Outpatient treatment of Mental Illness and Substance Use Disorder Treatment

Before September 1, 2019, your benefits for Outpatient treatment of Mental Illness and Outpatient Substance Use Disorder Treatment are limited to a combined maximum of 52 visits per benefit period. No Outpatient visit limits apply for services on or after September 1, 2019.

Benefit Payment for Inpatient treatment of Mental Illness and Substance Use Disorder Treatment

Benefits for the Inpatient treatment of Mental Illness and Inpatient Substance Use Disorder Treatment will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Benefit Maximum for Inpatient treatment of Mental Illness and Substance Use Disorder Treatment

Before September 1, 2019, you are entitled to a lifetime combined maximum of 120 Inpatient Hospital days for Inpatient treatment of Mental Illness and Inpatient Substance Use Disorder Treatment. No day limits apply for Inpatient services on or after September 1, 2019.

BARIATRIC SURGERY

Benefits for Covered Services received for bariatric Surgery will be provided under the HOSPITAL BENEFIT and PHYSICIAN BENEFIT sections of this benefit booklet.

Participating Providers

Benefits for bariatric Surgery when received from a Participating Provider will be provided at the Network percentage of the Eligible Charge or Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, after you have met your program deductible.

Non-Participating Providers

Benefits for bariatric Surgery when received from a Non-Participating Provider will be provided at the Non-Network percentage of the Eligible Charge or Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, after you have met your program deductible.

Benefits for bariatric Surgery received from a Non-Participating Provider are limited to the lifetime maximum amount shown in your Schedule of Benefits.

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 and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery.

If the newborn child needs treatment for an illness or injury, benefits will be available for that care only after you enroll the child and only if you have Employee Plus Child(ren) or full Family Coverage. If you do not already have such coverage, you must enroll for it no more than 90 days after the date of the birth. If you also want to enroll other family members, you must enroll them within 31 days after the birth. Claims for the newborn will not be paid until the child is actually enrolled, but coverage will be effective from the date of birth if the child is enrolled timely.

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

Coverage for an employee or spouse or civil union partner also includes benefits for elective abortions if legal where performed.

Benefits for Maternity Services or elective abortions will not be provided for dependent child(ren), except limited services when required by the Affordable Care Act or other applicable law.

INFERTILITY TREATMENT

Benefits will be provided the same as 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, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility or the inability to attain or maintain a viable pregnancy or 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.

Benefits for treatments that include oocyte retrievals will be provided only when you have been unable to attain or maintain a viable pregnancy or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that renders such treatment useless.

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

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

Special Limitations

Benefits 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. Please note, that benefits may be provided for fertility preservation as set forth in the FERTILITY PRESERVATION SERVICES provision of this benefit booklet.

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 the Claim Administrator.

6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

7. Infertility treatment rendered to dependent children.

8. Infertility treatment for a person who has undergone voluntary sterilization.

9. Infertility treatment for a person who is beyond normal child-bearing age.

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.

Your benefits for Assisted Reproductive Technologies (ART) will be subject to a lifetime maximum benefit if a maximum is shown in the Schedule of Benefits for your plan of benefits.

FERTILITY PRESERVATION SERVICES

Benefits will be provided for Medically Necessary Standard Fertility Preservation Services when a necessary medical treatment May Directly or Indirectly Cause Iatrogenic Infertility to you.

ROUTINE MAMMOGRAMS

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

- one baseline mammogram
- an annual mammogram

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

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

Participating Providers

Benefits for routine mammograms when received from a Participating Provider will be provided at 100% of the Eligible Charge or Maximum Allowance whether or not you have met your program deductible.

Non-Participating Providers

Benefits for routine mammograms when received from a Non-Participating Provider will be provided at 100% of the Eligible Charge or Maximum Allowance whether or not you have met your program deductible.

Benefit Maximum

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

MASTECTOMY-RELATED SERVICES

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

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge;

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

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

HEARING AIDS AND RELATED SERVICES

For Dependent Children to Age 18. Effective September 1, 2019, benefits are available for Medically Necessary hearing aids or devices and related services for children up to age 18 when a hearing care professional prescribes a hearing instrument. This includes coverage for one hearing instrument for each ear every 36 months. Repairs are covered when Medically Necessary. Covered related services include audiological exams and selection, fitting and adjustment of ear molds. Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance shown in the Schedule of Benefits for your plan of benefits, after you have met your program deductible.

For Participants Age 18 and Older. Effective September 1, 2020, benefits are available for Medically Necessary hearing aids and related services for Participants age 18 and older when a hearing care professional prescribes a hearing instrument to augment communication. This includes coverage for one hearing instrument for each ear every 24 months. Covered related services include services necessary to assess, select, fit and adjust the hearing instrument to ensure optimal performance, including but not limited to audiological exams, replacement ear molds, and repairs to the hearing instrument. Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance shown in your Schedule of Benefits, after you have met your program deductible, up to the maximum dollar benefit stated in your Schedule of Benefits.

PAYMENT PROVISIONS

Lifetime Maximum

Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited.

OUT-OF-POCKET EXPENSE LIMIT (OUT-OF-POCKET MAXIMUM)

There are separate out-of-pocket expense limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the amount of the Network Individual Out-of-Pocket Maximum shown in the Schedule of Benefits for your plan of benefits, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to 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 Non-Participating or Non-Administrator 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 Network 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:

- charges that exceed the Eligible Charge or Maximum Allowance

- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or a Non-Administrator Provider (other than Emergency care as described above)

- charges above the dollar limit for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet

- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

- **For Plan A, Plan B, Plan C, Plan E1, Plan AB1 and Plan M6 only:** Copayments for office visits, Hospital emergency room, urgent care facility, Inpatient Hospital Admission, Outpatient Surgery and prescription drugs

If you have Family Coverage and your out-of-pocket expense as described above equals the amount of the Network Family Out-of-Pocket Maximum shown in the Schedule of Benefits for your plan of benefits during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

For Non-Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the Non-Network Individual Out-of-Pocket Maximum shown in the Schedule of Benefits for your plan of benefits, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided.

The following expenses for Covered Services cannot be applied to the Non-Network 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:

- charges that exceed the Eligible Charge or Maximum Allowance

- the Coinsurance resulting from Covered Services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility

- charges above the dollar limit for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet

- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

- **For Plan A, Plan B, Plan C, Plan E1, Plan AB1 and Plan M6 only:** Copayments for Hospital emergency room, urgent care facility, Inpatient Hospital Admission, Outpatient Surgery and prescription drugs

If you have Family Coverage and your out-of-pocket expense as described above equals the Non-Network Family Out-of-Pocket Maximum shown in the Schedule of Benefits for your plan of benefits during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

Affordable Care Act (ACA) Cost Share Maximum

The ACA Cost Share Maximum applies only for Plan A, Plan B, Plan C, Plan E1, Plan AB1 and Plan M6.

If, during one benefit period, your Affordable Care Act expenses (the amount remaining unpaid after benefits have been provided) equal the Individual ACA Cost Share Maximum shown in your Schedule of Benefits, any additional Claims for Participating Providers during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This Affordable Care Act Cost Share Maximum may be reached by:

- All services that apply to the Network Out-of-Pocket Maximum;
- All Participating Provider Copayment amounts; and
- All prescription drug Copayments.

If you have Family Coverage and your Affordable Care Act expenses equal the Family ACA Cost Share Maximum shown in your Schedule of Benefits during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual Affordable Care Act Cost Share Maximum toward this amount.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

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

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 benefit booklet.

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 payment 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 under this Benefit Section only includes benefits for drugs and supplies which are self-administered. Benefits will not be provided for any self-administered drugs dispensed by a Physician. This section of your benefit booklet 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 benefit for drugs and supplies will be greater when you purchase them from a Participating Pharmacy. You can visit the Claim Administrator's website at *www.bcbsil.com* for a list of Participating Pharmacies. The Pharmacies that are Participating Prescription Drug Pharmacies may change from time to time. You should check with your Pharmacy before purchasing 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 benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

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

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

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

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

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

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

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

COVERED DRUG…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 is provided by a Health Care Practitioner;

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

(iv) Which is not consumed or administered at the time and place that the Prescription 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 Outpatient Prescription Drug Benefit Section).

DRUG LIST...means a list of drugs that may be covered under this Benefit Section. A current list is available on the Claim Administrator's website at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists. You may also contact a customer service representative at the telephone number shown on the back of your identification card for more information.

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

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

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

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

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

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

NON-PARTICIPATING PHARMACY OR NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER...has the meaning set forth in the DEFINITIONS SECTION of this benefit booklet.

NON-PREFERRED BRAND NAME DRUG...means a Brand Name Drug that is identified on the Drug List as a Non-Preferred Brand Name Drug. The Drug List is accessible by accessing the Claim Administrator's website at *www.bcbsil.com*.

PARTICIPATING PHARMACY OR PARTICIPATING PRESCRIPTION DRUG PROVIDER…has the meaning set forth in the DEFINITIONS SECTION of this benefit booklet.

PHARMACY...has the meaning set forth in the DEFINITIONS SECTION of this benefit booklet.

PREFERRED BRAND NAME DRUG...means a Brand Name Drug, that is identified on the Drug List as a Preferred Brand Name Drug. The Drug List is accessible by accessing the Claim Administrator's website at *www.bcbsil.com*.

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

SPECIALTY DRUGS...means prescription drugs 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, refer to the Drug List by accessing the Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

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

ABOUT YOUR BENEFITS

Drug List

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

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

The Drug List and any modifications will be made available to you. By accessing the Claim Administrator's website at *www.bcbsil.com* or calling the customer service toll-free number on your identification card, you will be able to determine the Drug List that applies to you and whether a particular drug is on the Drug List.

To the extent required by law, and subject to change as described above, all Covered Drugs indicated for the treatment of Substance Use Disorders are subject to the lowest Coinsurance Amount/Copayment Amount for a Generic Drug, Brand Name Drugs or Specialty Drugs, as applicable.

Prior Authorization/Step Therapy Requirement

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

Effective July 1, 2019: Step Therapy (ST): Your benefit program includes a step therapy program. This means you may need to try another proven, cost-effective medication before coverage may be available for the drug included in the program. Many brands have less-expensive generic or brand alternatives that might be an option for you.

To find out more about prior authorization/step therapy requirements or to determine which drugs or drug classes require prior authorization or step therapy, you should refer to the Drug List by accessing the Claim Administrator's web-site at *www.bcbsil.com* or call the customer service toll-free number on your identification card. Please refer to the Drug List provision of this section for more information about changes to these programs.

Request for Review: You, your prescribing health care Provider, or your authorized representative, can ask for an exception if your drug is not on (or is being removed from) the Drug List, if the drug requires prior authorization before it may be covered, or if the drug required as part of step therapy has been found to be (or likely to be) not right for you or does not work as well in treating your condition. To request this exception, you, your prescribing Provider, or your authorized representative, can call the number on the back of your identification card to ask for a review. The Claim Administrator will let you, your prescribing Provider, or authorized representative, know the coverage decision within 15 calendar days after they receive your request. If the coverage request is denied, the Claim Administrator will let you, your prescribing Provider, or authorized representative know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals and external exception review process you receive with the denial determination.

Request for Expedited Review: 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 prescribing Provider, or your authorized representative, may be able to ask for an expedited review process by making the review as an urgent request. The Claim Administrator will let you, your prescribing Provider, or authorized representative know the coverage decision within 72 hours after they receive your request for an expedited review. If the coverage request is denied, the Claim Administrator will let you, your prescribing Provider, or authorized representative know why it was denied and offer you a covered alternative drug(if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Call the number on the back of your identification card if you have any questions.

Dispensing Limits

Drug dispensing limits are designed to help encourage medication use as intended by the FDA. Coverage limits are placed on medications in certain drug categories. The Claim Administrator evaluates and updates dispensing limits quarterly.

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

Payment for benefits covered under this section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

To determine if a specific drug is subject to this limitation, you can refer to the Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

Day Supply

In order to be eligible for coverage under this benefit booklet, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation described in this benefit booklet. Payment for benefits covered under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Specialty Drugs are limited to a 30 day supply. For information on these drugs call the customer service toll-free number located on your identification card. However, early prescription refills of topical eye medication used to treat a chronic condition of

the eye will be eligible for coverage after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the prescribing Physician or Optometrist. For additional information about early refills, please see the **Prescription Refills** provision below.

Controlled Substances Limitations

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

Additional Copayment Amount and/or Coinsurance Amount and any deductible may apply.

Prescription Refills

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

- The prescription drugs are covered under this benefit booklet or have received an exception approval as described under the **Drug List** provision above;
- The prescription drugs are maintenance medications and have refill quantities available to be refilled at the time of synchronization;
- The medications are not Schedule II, III, or IV controlled substances as defined in the Illinois Controlled Substances Act;
- All utilization management criteria (as described under the **Prior Authorization/Step Therapy Requirement** provision above) for prescription drugs have been met;
- The prescription drugs can be safely split into short-fill periods to achieve synchronization; and
- The prescription drugs do not have special handling or sourcing needs that require a single, designated Pharmacy to fill or refill the Prescription;

When necessary to permit synchronization, Blue Cross and Blue Shield will prorate the Copayment Amount or Coinsurance Amount, on a daily basis, due for Covered Drugs based on the proportion of days the reduced Prescription covers to the regular day supply as describe below under the **BENEFIT PAYMENT FOR PRESCRIPTION DRUGS** provision in this Benefit Section.

COVERED SERVICES

Benefits for Medically Necessary Covered Drugs prescribed are available if the drug:

1. Has been approved by the FDA for the diagnosis and condition for which it was prescribed; or
2. Has been approved by the FDA for at least one indication; and
3. Is recognized by one of the following for the indication(s) of which the drug is prescribed to treat you for a chronic, disabling or life-threatening illness:
    a. a prescription drug reference compendium, or

b. substantially accepted peer-reviewed medical literature.

Some drugs are manufactured under multiple names and have many therapeutic equivalents. In such cases, the Claim Administrator 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 Coinsurance or Copayment Amount will apply to each fill of a medication having a unique strength, dosage, or dosage form.

Injectable Drugs

Benefits are available for Medically Necessary injectable drugs which are self- administered that require a written prescription by federal law. Benefits will not be provided under this Benefit Section 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.

Opioid Antagonists

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

Diabetic Supplies for Treatment of Diabetes

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

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

A separate Coinsurance or Copayment Amount will be required for both insulin and insulin syringes regardless if they are obtained on the same day.

Compound Drugs

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

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

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

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

Compound Drugs will be provided up to a maximum of $300. After the $300 maximum is reached, Prior Authorization will be required for any additional Compound Drugs.

Self-Administered Cancer Medications

Benefits are available for self-administered cancer medications, including pain medication.

Specialty Drugs

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

SELECTING A PHARMACY

Participating Pharmacy

When you choose to go to a Participating Pharmacy:

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

Participating Pharmacies have agreed to accept as payment from you the least of:

- the billed charges, or
- the Eligible Charge, or
- the amount for which you are responsible as described in your Schedule of Benefits and the Benefit Payment provisions later in this Benefit Section.

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

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

Non-Participating Pharmacy

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

- your appropriate Coinsurance or Copayment Amount; and
- any other amount for which you are responsible for the Covered Drugs you received.

Please refer to the provision entitled "Filing Outpatient Prescription Drug Claims" in the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet.

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 Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card. Mail the completed form, your prescription and payment to the address indicated on the form.

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

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

90-Day Retail Extended Supply Network (ESN) for Maintenance Drugs

In order to receive benefits for Maintenance Drugs, you must obtain these medications either through the Home Delivery Program or through one of the extended supply network (ESN) retail pharmacies. For a listing of Maintenance Drugs, you may access the website at *www.bcbsil.com* or contact customer service at the toll-free number on your identification card.

Benefits for Maintenance Drugs are available for the original prescription plus one refill at any retail Pharmacy. For the third fill of the medication, benefits are only available for Maintenance Drugs through the Home Delivery Program or through one of the extended supply network pharmacies. Benefits are not available if you continue to fill your prescription for Maintenance Drugs at a retail Pharmacy that is not an extended supply network Pharmacy.

When you obtain Maintenance Drugs from an extended supply network retail Pharmacy, benefits will be provided according to the Benefit Payment provisions described later in this Benefit Section.

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 Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

The Specialty Pharmacy Program delivery service offers:

- Coordination of coverage between you, your Health Care Practitioner and the Claim Administrator,
- 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 benefits for Specialty Drugs, you must obtain the Specialty Drugs from the Specialty Pharmacy Provider. When you obtain Specialty Drugs from the Specialty Pharmacy Provider, benefits will be provided according to the Benefit Payment provisions indicated in this Benefit Section.

Benefits will not be provided if you obtain Specialty Drugs from a Pharmacy other than the Specialty Pharmacy Provider.

YOUR COST

Out-of-Pocket Expense Limit

For Plan A, Plan B, Plan C, Plan E1, Plan AB1 or Plan M6: If you are enrolled in these plans, expenses you incur for Covered Services under this Benefit Section will not be applied towards the calendar year out-of-pocket maximum for your medical benefits but will be applied towards the ACA cost share maximum. If, during one benefit period, your ACA cost share maximum is reached, benefits for any additional eligible Claims for drugs or diabetic supplies during that benefit period will be paid at 100% of the Eligible Charge.

For Plan M3, Plan M7 or Plan M8: If you are enrolled in these plans, expenses you incur for Covered Services under this Benefit Section will be applied towards the calendar year out-of-pocket maximum for your medical benefits. If, during one benefit period, your out-of-pocket maximum is reached, benefits for any additional eligible Claims for drugs or diabetic supplies during that benefit period will be paid at 100% of the Eligible Charge.

Your out-of-pocket maximum and ACA cost sharing maximum (if applicable) are shown in the Schedule of Benefits for your plan of benefits.

BENEFIT PAYMENT FOR PRESCRIPTION DRUGS

How Member Payment is Determined

The amount you are responsible for is shown in the Schedule of Benefits for your plan of benefits. Your Copayments vary depending on the drug tier, as described below, the days' supply, and the Pharmacy you use (retail Pharmacy, retail extended supply network (ESN) Pharmacy, Home Delivery Program or the Specialty Pharmacy Provider). The drug tiers are:

- Tier 1 - Generic Drugs
- Tier 2 - Preferred Brand Name Drugs
- Tier 3 - Non-Preferred Brand Name Drugs

- Tier 4 - Specialty Drugs

If you or your Provider request a Brand Name Drug when a generic equivalent is available, you will be responsible for the Non-Preferred Brand Name Drug Copayment amount, plus the difference in cost between the Brand Name Drug and the generic equivalent, as determined by the Claim Administrator, except if your Physician indicates dispense as written on the prescription. The difference in cost between the Brand and its generic equivalent will not be applied toward the medical out-of-pocket maximum or the ACA cost share maximum, if applicable.

One retail Pharmacy Copayment applies for up to a 30-day supply of a covered prescription drug. If your Physician authorizes a 60-day supply of a drug and you choose to go to a retail Pharmacy, you will have to pay two (2) Copayment amounts for that 60-day supply. Certain drugs may be limited to less than a 60 consecutive day supply.

You may obtain up to a 90-day supply from a retail extended supply network Pharmacy or through the Home Delivery Program, but the Copayments are different, as shown in your Schedule of Benefits. Specialty Drugs are generally limited to a 30-day supply.

The following medications will be provided at 100% of the Eligible Charge and will not be subject to any Copayment Amount.

- Famotidine;
- Pepcid;
- Omeprazole OTC;
- Prilosec OTC;
- Lansoprazole OTC;
- Prevacid OTC;
- Ranitidine;
- Zantac;
- Nexium 24-hour OTC.

To receive additional information about your benefits for a drug, visit the Claim Administrator's website at *www.bcbsil.com* and log in to Blue Access for Members℠ (BAM) or call the number on the back of your identification card.

EXCLUSIONS

For purposes of this Prescription Drug Benefit Section only, the following exclusions shall apply. Some items excluded under this section may be covered under the Medical Benefit provisions of this Plan.

1. Non-FDA approved drugs.

2. Drugs which do not by law require a Prescription from a Provider or Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and certain OTC drugs that are covered as stated in this Benefit Section); and drugs or covered devices for which no valid Prescription is obtained.

3. Devices or durable medical equipment of any type (even though such devices may require a Prescription) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).

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

5. Administration or injection of any drugs.

6. Vitamins (**except** those vitamins which by law require a Prescription and for which there is no non-prescription alternative and vitamins for which coverage is required under the Affordable Care Act).

7. 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.

8. 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. This exclusion does not apply if you are not actually covered by Workers' Compensation or similar law unless you are required by applicable law to have such coverage but coverage was not in force.

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

10. Covered Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to your cost determined under this Benefit Section.

11. Drugs which are repackaged by a company other than the original manufacturer.

12. Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.

13. 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 in excess of the amount or beyond the time period allowed by law.

14. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.

15. 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 benefit booklet. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

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

17. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.

18. 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.

19. 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.

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

21. Prescriptions for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, except for generic omeprazole/lansoprazole, unless otherwise determined by the Claim Administrator.

22. Retin A or pharmacologically similar topical drugs for persons over the age of 39.

23. Athletic performance enhancement drugs.

24. Allergy serum and allergy testing materials.

25. Some therapeutic equivalent drugs are manufactured under multiple names. In some cases, benefits may be limited to only one of the therapeutic equivalents available. If you do not choose the therapeutic equivalents that are covered under this Benefit Section, the drug purchased will not be covered under any benefit level.

26. Certain drug classes where there are over-the-counter alternatives available.

27. Nonsedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant.

28. Brand Name Drugs in a drug class where there is an over the counter alternative available, except as otherwise stated in this Benefit Section.

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

30. Devices and pharmaceutical aids.

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

32. Surgical supplies.

33. Ostomy products (covered under the medical benefit provisions of the plan).

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

35. General anesthetics.

36. Bulk powders.

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

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

39. Benefits will not be provided for any self-administered drugs under this Benefit Section dispensed by a Physician.

40. Male condoms.

41. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes how benefits will be paid if you are also eligible for Medicare, consistent with the federal Medicare Secondary Payer (MSP) laws.

Active Employees and Their Dependents. Employers are required to offer active employees and their covered dependents who are age 65 and over the same health benefits offered to younger employees and dependents. If you are such an individual and choose coverage under this Plan and Medicare, this Plan will be your primary coverage and Medicare will be the secondary payor.

If this Plan is your primary coverage, this Plan will determine and pay its normal benefits first. You should then send Medicare a copy of the claim and a copy of this Plan's Explanation of Benefits (EOB) so that any balance can be considered for payment under Medicare.

Participants with End Stage Renal Disease (ESRD). Special rules apply if you are eligible for Medicare because you have end stage renal disease (kidney failure). In most cases, this Plan will be primary for the first 30 months you are eligible for Medicare due to ESRD. After 30 months, Medicare will be the primary payor and this Plan will pay secondary.

An exception applies if this Plan is already paying your claims secondary to Medicare when you become eligible for Medicare due to ESRD. This exception applies only if you were already eligible for Medicare due to age or disability and you are a retired employee, a dependent of a retired employee, a surviving dependent or a COBRA beneficiary. In these cases, this Plan will continue paying your claims secondary to Medicare in the manner described below.

Retired Employees and Their Dependents, Survivors and COBRA Beneficiaries. If you are eligible for Medicare due to age or disability and you are covered by this Plan as a Retiree, a dependent of a Retiree, a surviving dependent of a deceased former employee or a COBRA beneficiary, Medicare will be your primary coverage and this Plan will pay secondary to Medicare. **If eligible, you must enroll for both Medicare Part A and Part B.** This Plan will calculate the benefit it would have paid if you had no other coverage and then reduce its benefit payment by the amount paid by Medicare, or by the amount Medicare would have paid if you were enrolled in Medicare. This is true whether or not you are actually enrolled in both Part A and Part B unless you are not eligible for Medicare. This Plan will never pay more than the maximum amount the Provider is permitted to bill the patient under Medicare rules after Medicare pays its benefit.

If Medicare is your primary coverage you must send the Claim Administrator a copy of your Explanation of Medicare Benefits (EOMB) in order for your claim to be processed.

If you are retired and you and all your covered dependents are eligible for Medicare, it will be more cost effective to obtain other supplemental coverage instead of remaining in this Plan.

EXCLUSIONS - WHAT IS NOT COVERED

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

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

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, 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.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

— 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 set- ting, 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.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

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 the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator 's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

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

— 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, or if you are otherwise not required by Illinois law to be covered by such Act and do not in fact have such coverage.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, 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 were received prior to your Coverage Date or after the date that your coverage was terminated.

— Services or supplies from more than one Provider on the same day(s) to the extent benefits are duplicated.

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

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

— Custodial Care Service.

— Long Term Care Service.

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

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this benefit booklet.

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

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

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

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

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

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

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

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this benefit booklet.

— 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 benefit booklet or the Schedule of Benefits.

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

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability or mental disability, except as may be provided under this benefit booklet 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.

— Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet or your Schedule of Benefits.

— Hypnotism.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies,

screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

— 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 benefit booklet.

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

— Nutritional items such as infant formulas, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements, other than those specifically named in this benefit booklet.

— Reversals of sterilization.

— Prior to January 1, 2020, gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and related services and supplies are excluded, except for related counseling or psychotherapy services. Effective January 1, 2020, this exclusion does not apply and benefits for all such services will be provided on the same terms as other covered surgeries subject to applicable Medical Necessity and policy guidelines.

— Naprapathic Services.

— Maternity expenses for a Dependent child, except preventive care services required by the Affordable Care Act or as otherwise required by applicable law.

— Surgical removal of complete bony impacted teeth.

— Expenses for adoption.

— Services and supplies provided by a person who is a close relative.

— Services and supplies for complications from a treatment or service that is not covered under this benefit booklet.

— Services and supplies for treatment required due to Provider error or negligence.

— Exercise programs.

— Treatment for an addiction to gambling.

— Treatment for hair loss, unless specifically provided under this benefit booklet.

— Homeopathic treatment.

— Services and supplies for treatment rendered or provided due to an injury or illness occurring from an illegal occupation or in the commission of a felony, unless sustained due to a medical condition (physical or mental) or due to an act of domestic violence and benefits for such injuries are normally covered under this benefit booklet.

— Massage therapy.

— Expenses incurred for missing an appointment.

- Services and supplies rendered or provided for recreational or educational therapy.
- Services and supplies rendered or provided for refractive errors or lasik Surgery.
- Services and supplies rendered or provided due to a self-inflicted injury, except for self-inflicted injuries that result from a medical condition (physical or mental) or act of domestic violence and benefits for such injuries are normally covered under this benefit booklet.
- Services or supplies rendered or provided for sleep disorders.
- Expenses incurred for subrogation, reimbursement and/or third-party responsibility, unless specifically provided in this benefit booklet.
- Expenses for a surrogate pregnancy of a person not covered by this Plan.
- Services or supplies rendered or provided when you are admitted to a Hospital on a weekend, except for conditions which meet the definition of either Emergency Accident Care or Emergency Medical Care.
- Self-Administered drugs dispensed by a Physician.
- Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses, and group homes, except for Covered Services provided by appropriate Providers as defined in this benefit booklet.
- Any of the following applied behavioral analysis (ABA) related services:
    - Services with a primary diagnosis that is not Autism Spectrum Disorder;
    - Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of "Qualified ABA Provider" in the DEFINITIONS SECTION of this benefit booklet;
    - Activities primarily of an educational nature;
    - Shadow or companion services; or
    - Any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. COB does not apply to the Outpatient Prescription Drug Program Benefit Section.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.

2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this “birthday” type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

   — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

   — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

   Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator and, upon its request, to provide a copy of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

CONTINUATION OF COVERAGE DURING MILITARY LEAVE (USERRA)

An Employee who is absent from employment due to military service in the Uniformed Services has a right under the Uniformed Services Employment and Reemployment Rights Act (USERRA) to elect to continue coverage under this Plan for up to 24 months for the Employee and any Dependents who were covered at the time the leave began. Covered Dependents do not have an independent right to elect coverage under USERRA if you choose not to continue your own coverage, but your Dependents may separately elect COBRA continuation coverage.

To continue coverage under USERRA you must submit your election to continue coverage to your Employer's Human Resources Department within 60 days after the date your leave begins. If elected timely, coverage will be effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Participating Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA. If your military service is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of your Employer.

USERRA also requires that, regardless of whether you elect to continue coverage under the Plan during your military service, your coverage and coverage for your eligible Dependents must be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in USERRA. Contact your Employer for information concerning your eligibility for USERRA and any requirements of the Plan.

COBRA CONTINUATION COVERAGE

The right to COBRA continuation coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). COBRA continuation coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event."

This section is intended only to summarize your rights and obligations under the law. The law, however, is not clear on some points and is interpreted by Federal agencies and the courts. Therefore, this summary is subject to change without notice as interpretations or changes of the law occur. Both you and your Spouse or civil union partner should read this summary carefully and keep it with your records.

Before electing COBRA coverage you should also consider other options available when your Plan coverage terminates. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace.

By enrolling in coverage through the Marketplace you may qualify for lower premium costs and/or lower out of pocket costs. In addition, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan) even if that plan generally does not accept late enrollees.

Qualified Beneficiaries

In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan are considered "qualified beneficiaries" who are eligible to elect COBRA continuation coverage.

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

A civil union partner of an Employee generally is not entitled to continue coverage under the COBRA law; however the Trust has chosen to extend COBRA-equivalent coverage to civil union partners and children of a civil union

partner. This COBRA-equivalent coverage is identical to the COBRA continuation coverage offered to a Spouse or Dependent child of an Employee.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) has an independent right to elect to receive COBRA continuation coverage. You and/or your Spouse or civil union partner may elect coverage on behalf of either one of you and parents may elect coverage on behalf of a Dependent Child.

Qualifying Events

Continuation for Up to 18 Months

If you are a covered Employee, you, your Spouse or civil union partner and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either of the following qualifying events:

1. Your hours of employment are reduced below the minimum required to maintain eligibility; or

2. Your employment ends for any reason other than your gross misconduct.

You, your Spouse or civil union partner and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll for COBRA coverage within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA continuation coverage. The 18-month period may be extended in the circumstances described in the Extension of 18-Month Continuation Coverage Period section below.

Continuation for up to 36 Months

If you are the Spouse or civil union partner and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

1. The spouse/parent-Employee dies;

2. The spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B or both);

3. The Employee and spouse/parent become divorced or legally separated or a civil union is terminated; or

4. A Dependent Child ceases to meet the requirements to qualify as a Dependent Child under this Plan.

Your Spouse or civil union partner and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse or civil union partner and/or Dependent Child provide timely notice of the qualifying event to your Human Resources Department and elect to enroll for COBRA coverage within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA continuation coverage. Please see the section below entitled Notice Requirement for the requirements of such notice.

IMPORTANT NOTE: Under this Plan Dependents generally do not lose coverage if the Employee dies, Employees and their Dependents generally do not lose coverage if the Employee retires and receives a pension from IMRF or TRS, and Retirees and Employees generally do not lose coverage when they become eligible for Medicare. In cases where the event does not cause loss of coverage, Employees and their Dependents do not need to elect COBRA continuation coverage. However, they will need to elect Retiree coverage upon an Employee's retirement or coverage as surviving Dependents in the event of the death of an Employee or Retiree.

Even though these events will not require converting to COBRA coverage, an Employee's death, retirement or eligibility for Medicare will be considered a COBRA qualifying event for purposes of measuring the period during

which the Employee's Dependents retain COBRA rights. If another event occurs that causes the Dependents to lose coverage under the Plan, all coverage from the date of the initial COBRA qualifying event will be counted in determining the maximum COBRA coverage period. For example, if an Employee or Retiree decides to drop Plan coverage due to Medicare eligibility or eligibility for medical benefits under TRS or IMRF, Dependents of the Employee or Retiree will lose their coverage. The Dependents may elect continuation coverage under these COBRA rules for any remaining portion of the COBRA coverage period if the loss of regular coverage occurs within the maximum COBRA coverage period, measured from the date of the initial qualifying event (death of the Employee or retirement/termination of employment or eligibility for Medicare). Dependents whose regular coverage has been continued under the terms of the

Plan beyond the maximum COBRA coverage period, measured from the date of the initial qualifying event, may not elect continuation coverage under these COBRA rules.

Extension of 18-Month Continuation Coverage Period

Disability Extension. If you, your Spouse or civil union partner or Dependent Child is determined to be disabled by the Social Security Administration (SSA), you and all other qualified beneficiaries in the 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 must be determined by SSA to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA coverage. To qualify for this extension you must notify your Human Resources Department within 60 days after the date the SSA determination is issued and prior to the end of the initial 18-month period of COBRA coverage. If you or your family member is later determined by SSA to no longer be disabled, you must notify your Human Resources Department within 30 days after you receive such determination. Please see the section below entitled “Notice Requirement” for the requirements of such notice.

Second Qualifying Event Extension. If your family experiences a second qualifying event (for example, the Employee dies or a divorce occurs or a child reaches the limiting age) while enrolled for 18 months of COBRA continuation coverage, your Spouse or civil union partner and any Dependent Child affected by the second qualifying event may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension you must notify your Human Resources Department within 60 days after the later of (a) the date of the second qualifying event or (b) the date you would lose coverage on account of the qualifying event. Please see the section below entitled “Notice Requirement” for the requirements of such notice.

Notice Requirement

The Employee or a family member has the responsibility to notify the Employer of a divorce, legal separation, termination of a civil union or a child losing dependent status under the Plan. You or your family member must give this notice no later than 60 days after the date of the applicable event. **If you fail to give this notice during the 60-day period, the Dependents who would otherwise be eligible for COBRA will not be offered the option to elect continuation coverage.**

When the Employer is notified that one of these events has happened, the Employer must notify the Enrollment Administrator. The Employer must also notify the Enrollment Administrator if one of the following events occurs and results in a loss of coverage: the Employee's retirement or other termination of employment, reduction in hours, death, or the Employee becoming entitled to Medicare. The Enrollment Administrator will then notify you in writing that you have the right to elect continuation coverage.

You must elect continuation coverage within 60 days after your regular Plan coverage ends, or, if later, within 60 days after you are notified of your right to elect continuation coverage. If you do not elect continuation coverage within this 60-day period, you will lose your right to elect continuation coverage.

The notice must be postmarked (if mailed) or received by the Enrollment Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost. This means if you intended to elect COBRA continuation coverage, your coverage under the Plan will terminate on

the last date for which you are eligible under the terms of the Plan, or if you intended to extend your COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse, termination of a civil union, or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

1. Name and address of the covered Employee or former employee;

2. Name and address of your Spouse, former Spouse or civil union partner and any Dependent Children;

3. Description of the qualifying event; and

4. Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

1. Name of person deemed disabled;

2. Date of disability determination; and

3. Copy of SSA determination letter.

If you cannot provide a copy of the decree of divorce or the SSA’s determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the Enrollment Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Enrollment Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse or civil union partner may obtain a copy by requesting it from the Enrollment Administrator at the address provided in this notice.

Notice must be sent to the Enrollment Administrator at:

HealthSCOPE Benefits
P. O. Box 2459
Little Rock, AR 72203
1-877-385-8775

Payment for COBRA Continuation Coverage

If you elect continuation coverage, the Plan must provide coverage that, as of the time coverage is provided, is identical to the coverage provided under the Plan to similarly situated Employees or family members. If the coverage for similarly situated Employees or family members is modified, your coverage will be modified.

You must pay the premium payment for your "initial premium month" and subsequent months to bring your payments current, by the 45th day after you elect continuation coverage. Your initial premium month is the first month after your regular Plan coverage terminates. All future premiums are due on the 1st of the month for which the premium is due, subject to a 30-day grace period.

COBRA premium rates will be determined as follows:

1. Employee only: Employee rate plus 2% administration charge;

2. Employee and Spouse/Partner: Employee + Spouse/Partner rate plus 2%;

3. Employee and Child or Children: Employee + Child or Children rate plus 2%;

4. Employee and Spouse/Partner and One or More Children: Family rate plus 2%;

5. Spouse/Partner only: Difference between Employee + Spouse/Partner rate and Employee rate plus 2%;

6. One or More Children: Difference between Employee + Child or Children rate and Employee rate plus 2%;

7. Spouse/Partner and One or More Children: Difference between Family rate and Employee rate plus 2%.

Termination of COBRA Continuation Coverage

COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however COBRA coverage under this Plan may end before the end of the maximum period on the earliest of the following events:

1. The date your Employer withdraws from the Trust or ceases to provide any group health plan coverage.

2. The date on which the qualified beneficiary fails to pay the required contribution.

3. The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first).

4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Additional Information

Additional information about the Plan and COBRA continuation coverage is available from your Employer or the Enrollment Administrator identified above and in the General Plan Information section of this benefit booklet.

If your marital status or civil union status changes, or a Dependent ceases to be a Dependent eligible for coverage under the Plan terms, you must immediately notify your Employer.

You should also keep your Employer and the Enrollment Administrator informed of any changes in the addresses of covered family members.

HOW TO FILE A CLAIM AND APPEALS PROCEDURES

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your identification card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator 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 your benefits were calculated. In some cases the Claim Administrator 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 the Claim Administrator'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 the Claim Administrator's 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 the Claim Administrator 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, call the Claim Administrator's 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 will not 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 the Claim Administrator's 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:

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

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.

Should you have any questions about filing Claims, please call the Claim Administrator.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Claim Administrator will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator does not process a Claim within this 30-day period, you or your 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 day payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim Administrator 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 benefit booklet.)

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 determination is based, or the contractual, administrative, medical policy 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), diagnosis, treatment and determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

e. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review);

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

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

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 determination 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 determination 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.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator's offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday. Customer service hours and operations are subject to change without notice.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112
1-800-538-8833 Toll-free phone

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 identification card for contact information.

INQUIRIES AND COMPLAINTS

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

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

The Claim Administrator 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 an Adverse Benefit Determination (or partial determination), then you have the right to a Claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

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

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

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

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees or a Provider.

The following is the contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For Complaints and general Inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
Consumer_complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Timing of Required Notices and Extensions

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

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

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

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

Urgent Care Clinical Claims*

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

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

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

Pre-Service Claims

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

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

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

Post-Service Claims

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

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

Concurrent Care

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

CLAIM APPEAL PROCEDURES - DEFINITIONS

An **"Adverse Benefit Determination"** means a determination, 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 determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of

coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

Urgent Care/Expedited Clinical Appeals

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

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Claim Administrator will render a decision on the appeal within 24 hours after it receives the requested information, but not more than 72 hours from the appeal request.

Standard or Non-Urgent Appeals

The Claim Administrator will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan. Under your plan there are two levels of internal appeal available to you.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your identification card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

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

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a Claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination.

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

- The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, with to file a complaint or wish to take up your matter with the IDOI, you may use either address below:

IDOI Consumer Division
320 W. Washington St.
Springfield, Illinois 62767
1-217-782-4515

or

IDOI Consumer Division
122 S. Michigan Ave., 19th Floor
Chicago, Illinois 60603
1-312-814-2420
web: *http://insurance.Illinois.gov*

Your Right to Appeal
You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case. Send a written appeal request to: The Claim Administrator Claim Review Section P.O. Box 2401 Chicago, Illinois 60690
To file an appeal or if you have questions, please call 800-538-8833 (TTY/TDD:711, send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members (BAM) at *bcbsil.com*

During the course of your internal appeal(s), the Claim Administrator will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by the Claim Administrator in connection with the appealed Claim, as well as any new or additional rationale for a determination at the internal appeals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. The Claim Administrator may extend the time period described in this benefit booklet for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial determination of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.

Second Appeal Level Following Adverse Decision on First Appeal

If you do not agree with the Claim Administrator's determination from the first level of appeal, you have 60 days to file a second appeal. You will have the same rights during the second appeal as you had during the first appeal. Your second appeal must be in writing and must include all of the items set forth in the section above entitled "How to Appeal an Adverse Benefit Determination." You may submit your second appeal in writing, along with any additional information you wish to submit supporting your appeal, to:

Egyptian Area Schools Employee Benefits Trust
Attn: Appeals Committee
P. O. Box 2034
Loves Park, IL 61130

The Appeals Committee of the Board of Managers has final responsibility for deciding second level appeals from Participants. The Appeals Committee will review the information initially received and any additional information you choose to provide and make a determination on the appeal based on the terms and conditions of the Plan and other relevant information. No individually identifiable information will be disclosed to the Appeals Committee or other members of the appeals process unless you choose to participate in person at the appeal meeting or you submit a signed authorization form asking the Appeals Committee to consider information that identifies you in connection with your appeal. If the Appeals Committee denies your appeal, you may have the right to an independent external review of your claim, as described in the EXTERNAL REVIEW sections below.

Timing of Non-Urgent Appeal Determinations

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

The Claim Administrator will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 calendar days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 30 calendar days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you have already received the service.

If the appeal is related to administrative matters or Complaints, the Claim Administrator 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

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal.

The written notice will include:

1. The reasons for the determination;

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

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

4. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or an external review);

5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative;

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

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

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

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

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

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

12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;

13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review;

14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a Provider appeal.

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

You may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the Complaint. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

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

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO). The external review is at no charge to the member.

An "**Adverse Benefit Determination**" means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure

to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

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

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:

   a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

   b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

   c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and

   d. You or your authorized representative have provided all the information and forms required to process an external review.

   You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice and provide contact information for the U. S. Department of Health and Human Services Health Insurance Assistance Team (HIAT) (toll-free number 866-393-2789).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, the Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection).

In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the determination of benefits.

The IRO must provide the following:

a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;

(4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous determination);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim

Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. **Request for expedited external review.** Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review,

you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under federal or State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator 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 the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator'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 the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet 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. The Plan Sponsor has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between the Plan Sponsor and the Claim Administrator. Neither the Plan, your Employer 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 the Claim Administrator'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 benefit booklet.

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, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator 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 the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator 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. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor the Plan are entitled to any part of these savings.

INTER-PLAN ARRANGEMENTS

Out-of-Area Services

Overview

The Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association"). Whenever you access healthcare services outside the geographic area the Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Claim Administrator's 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") do not contract with the Host Blue. The Claim Administrator explains below how the Claim Administrator pays both kinds of Providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the Claim Administrator to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, the Claim Administrator will remain responsible for doing what we agreed in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

For Inpatient facility services received in a Hospital, the Host Blue's participating Provider is required to obtain Preauthorization. If Preauthorization is not obtained, the participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction.

When you receive Covered Services outside the Claim Administrator'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 charges for Covered Services, or
- The negotiated price that the Host Blue makes available to the Claim Administrator.

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 Claim Administrator.

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 Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator 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 benefit booklet and your Schedule of Benefits.

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 modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Claim Administrator has used for your claim because they will not be applied after a Claim has already been paid.

B. Special Cases: Value Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claim Administrator through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If the Claim Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your Employer on your behalf, the Claim Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Claim Administrator will include any such surcharge, tax or other fee as part of the Claim Charge passed on to you.

D. Non-Participating Healthcare Providers Outside The Claim Administrator's Service Area

a. Member Liability Calculation

(1) In General

When Covered Services are provided outside of the Claim Administrator's service area by non-participating Providers, the amount(s) you pay for such services will be calculated

using the methodology described in the benefit booklet 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 Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, the Claim Administrator may, but is not required to, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then the Claim Administrator may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area (and described in Section (1) above); or

2. The following:

(i) For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or

(ii) For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield

Global Core assists you with accessing a network of Inpatient, Outpatient and Professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost-share amounts/Deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. You must contact the Claim Administrator 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 Blue Cross Blue Shield Global Core Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the Claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your Claim. The claim form is available from the Claim Administrator, the service center or online at www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. THE CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Claim Administrator's Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers (“Participating Prescription Drug Providers”) to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under this Health Care Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator 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 the Claim Administrator may receive such discounts. Neither the Plan, your Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

For the home delivery pharmacy and specialty pharmacy program partially 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 Claim Administrator pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and home delivery processing.

“Weighted Paid Claim" refers to the methodology of counting Claims for purposes of determining the Claim Administrator's fee payment to Prime. Each retail (including Claims dispensed through PBM's Specialty Pharmacy program) paid Claim will be weighted according to the days' supply dispensed. A paid Claim is weighted in 34 day supply increments, so a 1-34 days' supply is considered 1 weighted Claim, a 35-68 days' supply is considered 2 weighted Claims, and the pattern continues up to 6 weighted Claims for 171 or more days' supply. The Claim Administrator pays Prime a Program Management Fee (“PMF”) on a per weighted Claim basis.

The amounts received by Prime from the Claim Administrator, 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 Claim Administrator (as described above), administrative fees charged by Prime to Pharmacies and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this benefit booklet. Additional information about these types of fees or the amount of these fees is available upon request. As of the effective date, the maximum that a PBM has disclosed to the Claim Administrator that the PBM will receive from any pharmaceutical manufacturer for manufacturer administrative fees is five and a half percent (5.5%) of the Wholesale Acquisition Cost (“WAC”) for all products of

such manufacturer dispensed during any given calendar year to members of the Claim Administrator and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to the PBM at the request of the Claim Administrator; provided, however, that the Claim Administrator will advise the Employer if such maximum has changed.

Claim Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC. Neither the Plan, your Employer nor you are entitled to receive any portion of such rebates.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator, 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 Claim Administrator may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates.

3. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator 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 the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

c. A covered person's claim for benefits and any rights as a Participant under this Health Care Plan are expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a covered person. Coverage under this Health Care Plan 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 any rights or any claim for benefits or coverage shall be null and void.

4. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

c. The use of an adjective such as Participating, Administrator, Preferred or approved 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 Participating, Administrator, Preferred or approved or any similar modifier or the use of a term such as Non-Administrator 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 interact with or provide any services to your Employer (other than as an individual covered person) or your Employer's Health Benefit Program.

5. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

6. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. 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 the Claim Administrator in accordance with the requirements described in this benefit booklet. Before filing any legal action a Participant must exhaust all available internal levels of administrative review as described in this benefit booklet, unless an exception applies under applicable law. No legal action shall be brought against the Plan or the Plan Sponsor more than one year after the date of the final notice of Adverse Benefit Determination on the final level of internal or external review, whichever applies. Any legal action brought against the Plan or the Plan Sponsor must be brought in federal or state court in the State of Illinois.

7. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (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 the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator 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 the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator will be able to make Claim Payments in accordance with MSP laws.

8. OVERPAYMENT

If your group's benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error

("Overpayment"), your group's plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or

b. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future benefit payment owed to one or more Participating or Non-Participating Providers.

Further, the Claim Administrator has the right to reduce your benefit plan's payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan Overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield's plan.

9. VALUE BASED DESIGN PROGRAMS

The Claim Administrator and the Plan and your Employer have the right to offer medical management programs, quality improvement programs and health behavior wellness, incentive, maintenance, or improvement

programs that allow for a reward, a contribution, a penalty, a differential in premiums or a differential in medical, prescription drug or in equipment Copayments, Coinsurance or deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by the Claim Administrator or an entity chosen by the Claim Administrator to administer such programs.

In addition, discount or incentive programs for various health and wellness-related, insurance-related, or other items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Contact the Plan or your Employer for additional information regarding any value-based programs offered by the Plan or your Employer.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

END OF BENEFIT BOOKLET

The information which follows is provided to you by Egyptian Area Schools Employee Benefit Trust. The Claim Administrator is not responsible for its contents.

HIPAA PRIVACY RULE

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act ("HIPAA") created federal privacy rights with respect to medical information. The Plan is required by law to provide Participants with a Notice explaining the Plan's privacy practices and how the Plan may use and disclose your medical information for treatment and payment purposes and for other purposes permitted or required by law. The Notice also describes certain rights you have with respect to your medical information maintained on behalf of the Plan.

The Trust's Notice of Privacy Practices is available at the HIPAA Authorization Notice and Form page on the Trust's website at www.eg.trust.org. You may obtain a paper copy by calling 1-800-397-9598.

The Egyptian Trust does not have its own employees. Most of the Plan's operations are handled by third party Business Associates which perform various administrative and other services for the Trust. All of the PHI (defined below) created or received by or for the Plan is maintained by its Business Associates, and the terms "Trust" and "we" in the Notice generally mean the Trust and its Business Associates when they are acting on behalf of the Plan. Whenever an arrangement between the Trust and a Business Associate requires the use or disclosure of PHI, we will have a written contract that contains terms that will protect the privacy of your PHI as provided in the Notice. For example, the Trust has contracts with the Claim Administrator (BCBSIL) and other service providers which require these Business Associates to protect the privacy of your PHI to the same extent that the Trust is required to protect your PHI.

The Claim Administrator's HIPAA Notice of Privacy Practices and its Standard Authorization to Release PHI form are also available on the Trust's website or by contacting the Claim Administrator at 1-855-686-8517.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by or for the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

1. The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy Standards will be implemented and enforced in the offices of the Plan Sponsor and any other entity that may assist in the operation of the Plan. The Plan is required by law to take reasonable steps to ensure the privacy of Participants' PHI, and inform Participants about:

2. The Plan's disclosures and uses of PHI;

3. The Participant's privacy rights with respect to their own PHI;

4. The Plan's duties with respect to PHI;

5. The Participant's right to file a complaint with the Plan and with the Secretary of HHS; and

6. The person or office to contact for further information about the Plan's privacy practices.

How Health Information May be Used and Disclosed

In general, the Privacy Rule permits the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;

2. For Health Care Operations;

3. For Treatment purposes; or

4. If the use or disclosure falls within one of the limited circumstances described in the Privacy Rule (e.g., the disclosure is required by law or for public health activities).

Refer to the Notice of Privacy Practices for more detailed information about how your PHI may be used and disclosed. Except as described in the Notice of Privacy Practices and in this section, other uses and disclosures of your PHI may only be made with your written authorization.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

The Plan may disclose PHI to the Plan Sponsor for purposes of plan administration or pursuant to an authorization request signed by the Participant. In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose genetic information for underwriting purposes;

7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to a written authorization which meets the requirements of the Privacy Standards;

8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);

12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

14. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

15. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    a. The following persons under control of the Plan Sponsor shall be given access to the PHI to be disclosed: the Privacy Officer, the officers of the Plan Sponsor and members of the Appeals Committee. The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

    b. In the event any of the individuals described above do not comply with the requirements of the Privacy Rule relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan and will cooperate with the Plan to correct violation or non-compliance and impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively so that they are commensurate with the severity of the violation.

Rights of Individuals

Plan Participants have the following rights regarding their own PHI, as more fully described in the Notice of Privacy Practices:

1. Request Restrictions: You have the right to request additional restrictions on the use or disclosure of your PHI for treatment, payment, or health care operations. You may request the Plan to restrict disclosures to family members, relatives, friends or other persons you identify who are involved in your care or payment for your care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and explain how you prefer to be contacted. The Plan will accommodate all reasonable requests.

3. Right to Receive a Notice of Privacy Practices: You are entitled to receive a paper copy of the Plan's Notice of Privacy Practices at any time. Contact the Privacy Officer to obtain a paper copy.

4. Accounting of Disclosures: You have the right to request an accounting of disclosures the Plan has made of your PHI. The request must be made in writing in the manner described in the Notice of Privacy Practices and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes.

5. Access: You have the right to request the opportunity to look at or obtain copies of your PHI in certain records maintained by the Plan, as described in the Notice of Privacy Practices.

6. Amendment: You have the right to request that the Plan change or amend your PHI. Submit the request to the Privacy Officer. The Plan may deny your request in certain cases, including if it is not in writing or if you do not provide a reason for the request.

Questions or Complaints

If you want more information about the Plan's privacy practices, have questions or concerns, or believe the Plan may have violated your privacy rights, please contact the Plan using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services or the Attorney General of the State of Illinois. The Plan will provide you with addresses for filing such complaints upon request. The Plan will not retaliate against you for filing a complaint.

Contact Information

Privacy Officer
Egyptian Area Schools Employee Benefit Trust
P. O. Box 2034
Loves Park, IL 61130
Phone: 1-800-397-9598

HIPAA SECURITY RULE

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that the Plan creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.

4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:

    a. Written notice by first-class mail to Participant (or next of kin) at last known address or, if specified by Participant, e-mail;

    b. If Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a substitute form;

    c. If an urgent notice is required, the Plan may contact the Participant by telephone.

The breach notification will have the following content:

a. Brief description of what happened, including date of breach and date discovered;

b. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);

c. Steps the Participant should take to protect from potential harm;

d. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.

3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.

4. When a Business Associate which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

TELADOC

The Plan provides coverage for telephone consults or e-mail consults provided by a Teladoc Physician for non-emergent care. Common examples of when to use Teladoc for non-emergent medical care include but are not limited to the following: care after office hours; care while on vacation; to refill a short term (non-DEA controlled) prescription; second opinions; and research and advice on a particular health condition. To utilize this service, please visit www.MyDrConsult.com directly or you may visit www.egtrust.org to hyperlink to Teladoc. If you do not have internet service available, please call 1-800-362-2667 to use this service. If a prescription is requested, you will be required to complete an electronic medical record prior to receiving a consult. This electronic medical record is confidential and will be maintained by the Teladoc program. For any questions about the Teladoc benefit, please contact Health SCOPE Benefits Customer Care at 1-800-397-9598.

This benefit does not include telephone or e-mail consults from your regular Physician; it only includes coverage for telephone or e-mail consults to the extent the Physician who is consulted participates in the Teladoc program. The Teladoc benefit is not available in the State of Oklahoma.

Administered by:

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

ASO-1
Effective Date: March 1, 2019
www.bcbsil.com