

**BENEFIT SCHEDULE C**

**Farm Credit Foundations  
Consumer Choice PPO Option  
(Group Nos. 016774 & 016777)**

# Farm Credit Foundations Consumer Choice PPO Option

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## **I. NOTICE**

With respect to your medical care benefits, please note that BlueCross and BlueShield of Illinois (“BCBSIL”) has contracts with many health care Providers which permit BCBSIL 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. You may refer to the provision entitled “BCBSIL’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this Benefit Schedule for a further explanation of these arrangements. BCBSIL provides administrative Claims payment services only and does not assume any financial risk or obligation with respect to Claims.

With respect to your prescription drug benefits, please note that CVS Caremark also has contracts with many retail pharmacies and pharmaceutical companies which permit CVS Caremark to receive certain discounts on the prescription medication that you receive. Pursuant to those contracts, the pharmacies participating in CVS Caremark’s national retail pharmacy network have agreed to fill your prescriptions at specified costs and to process prescription benefit Claims on your behalf.

### **LIMITED MEDICAL BENEFITS FOR NON-PARTICIPATING PROVIDERS**

You should be aware that when you elect to receive Covered Services from a Non-Participating Provider in non-emergency situations, the amount of the benefit payment to such Non-Participating Provider will be a reduced benefit payment than what would have been made if services had been rendered by a Participating Provider. **Non-Participating Providers will be paid for Eligible Charges at a rate of 90% of the Health Insurance Association of America (“HIAA”) index. You can expect to pay the difference between that 90% rate and the actual billed charges.** By way of contrast, Participating Providers have agreed to accept the Maximum Allowance with no additional billing after you have paid your Coinsurance and Deductible amount.

You may obtain further information about the participating status of various Providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

## II. BENEFIT HIGHLIGHTS

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

### MEDICAL BENEFITS

#### MAXIMUM COVERAGE PER BENEFIT PERIOD

Lifetime Maximum for all Benefits	Unlimited
Individual Deductible	\$2,700 per Benefit Period
Family Deductible	\$5,450 per Benefit Period
Employee Plus Spouse Deductible	\$5,450 per Benefit Period
Employee Plus Child(ren) Deductible	\$5,450 per Benefit Period
Individual Out-of-Pocket Expense Limit <b>(does not apply to all services)</b>	
— Participating Provider	\$2,700 per Benefit Period
— Non-Participating Provider	\$5,400 per Benefit Period
Family Out-of-Pocket Expense Limit	
— Participating Provider	\$5,450 per Benefit Period
— Non-Participating Provider	\$10,900 per Benefit Period
Employee Plus Spouse Out-of-Pocket Expense Limit	
— Participating Provider	\$5,450 per Benefit Period
— Non-Participating Provider	\$10,900 per Benefit Period
Employee Plus Child(ren) Out-of-Pocket Expense Limit	
— Participating Provider	\$5,450 per Benefit Period
— Non-Participating Provider	\$10,900 per Benefit Period
Wellness Care Benefit Maximum	\$750 per Benefit Period
Chiropractic and Osteopathic Manipulations Benefit Maximum	\$2,000 per Benefit Period
Physical Therapy Services *	\$5,000 per Benefit Period
Benefit Maximum	
Occupational Therapy Benefit Maximum	\$5,000 per Benefit Period
Speech Therapy *	\$5,000 per Benefit Period
Benefit Maximum	

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\* With respect to Physical Therapy and Speech Therapy benefits, the \$5000 per Benefit Period limit on coverage does not apply to Physical Therapy or Speech Therapy necessitated by congenital defects, birth abnormalities, or developmental growth abnormalities (e.g., cerebral palsy).

Temporomandibular Joint Dysfunction and Related Disorders Lifetime Maximum	\$2,500
Combined Inpatient and Outpatient Substance Abuse Rehabilitation Treatment Maximum	\$10,000 per Benefit Period
Combined Lifetime Maximum for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment	\$20,000
Outpatient treatment of Mental Illness Benefit Maximum	45 visits per Benefit Period
Inpatient Mental Illness treatment Benefit Maximum	30 days per Benefit Period

PROFESSIONAL SERVICE BENEFITS

General Payment Level

- Participating Provider 100% of the Eligible Charge after Deductible
- Non-Participating Provider 60% of the Eligible Charge after Deductible

Office Visit and Urgent Care Coinsurance

- Participating Provider 100% of the Eligible Charge not subject to Deductible
- Non-Participating Provider 60% of the Eligible Charge after Deductible

Emergency Room

- Participating Provider 100% of the Eligible Charge after Deductible
- Non-Participating Provider 60% of the Eligible Charge after Deductible

HOSPITAL BENEFITS

Payment level for Inpatient Covered Services

- Participating Provider 100% of the Eligible Charge
- Non-Participating Provider 60% of the Eligible Charge

Payment level for Outpatient Covered Services

- Participating Provider 100% of the Eligible Charge
- Non-Participating Provider 60% of the Eligible Charge

Payment level for Outpatient treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment

- Participating Provider 100% of the Eligible Charge
- Non-Participating Provider 60% of the Eligible Charge

Hospital Emergency Care

- Payment level for Emergency Accident Care from either a Participating or Non-Participating Provider 100% of the Eligible Charge

PHYSICIAN BENEFITS

Payment level for Surgical/Medical Covered Services

- Participating Provider 100% of the Maximum Allowance
- Non-Participating Provider 60% of the Maximum Allowance

Payment level for Emergency Accident Care when rendered by a Physician

- Participating Provider 100% of the Maximum Allowance
- Non-Participating Provider 100% of the Maximum Allowance

Payment level for Outpatient treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment

- Participating Provider 100% of the Maximum Allowance
- Non-Participating Provider 60% of the Maximum Allowance

Additional Surgical Opinion 100% of the Claim Charge, no Deductible

OTHER COVERED SERVICES

Payment level 100% of the Eligible Charge or Maximum Allowance

HEARING BENEFITS

- Benefit Payment Level 100% of the Usual & Customary Fee
- Hearing Aids  
Benefit Maximum \$1,500 per covered person every 3 years

PRESCRIPTION BENEFITS

- Network Retail Pharmacy 100% of cost of eligible Prescription Drugs after Deductible is met
- Non-Network Retail Pharmacy 100% of cost of eligible Prescription Drugs after Deductible is met

### **III. DEFINITIONS SECTION**

Throughout this Benefit Schedule, 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 Schedule, 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, it means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

**ADMINISTRATOR PROGRAM**.....means programs for which a Hospital has a written agreement with BCBSIL or a BlueCross and BlueShield Plan or BlueCross Plan of another state 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.

**AMBULANCE TRANSPORTATION**.....means local or air transportation in a specially equipped certified vehicle 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.

**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.

**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.

**AUDIOLOGIST**.....means a duly licensed audiologist.

**AVERAGE DISCOUNT PERCENTAGE (“ADP”)**.....means a percentage discount determined by BCBSIL that will be applied to a Provider’s Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, Deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by BCBSIL to be relevant to the particular Claim. The ADP reflects BCBSIL’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 Schedule regarding “BCBSIL’s Separate Financial Arrangements with Providers.”) In determining the ADP applicable to a particular Claim, BCBSIL will take into account differences among Hospitals and other facilities, BCBSIL’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 Medical Plan are secondary to Medicare and/or coverage under any other group program.

**BCBSIL**.....means BlueCross BlueShield of Illinois.

**BENEFIT PERIOD**.....means the period of one year which begins on January 1<sup>st</sup> of each year. When you first enroll under this coverage, your first Benefit Period begins on your Coverage Date and ends on the first December 31<sup>st</sup> following that date.

**BRAND NAME DRUG**.....means a trademarked Prescription Drug.

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

- (i) Is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) Is a graduate of an advanced practice nursing program.

A “**Participating Certified Clinical Nurse Specialist**” means a Certified Clinical Nurse Specialist who has a written agreement with BCBSIL or another BlueCross and BlueShield Plan or BlueCross 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 BCBSIL or another BlueCross and BlueShield Plan or BlueCross 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
- (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 BCBSIL or a BlueCross and BlueShield Plan or BlueCross Plan of another state 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 BCBSIL or a BlueCross and BlueShield Plan or BlueCross Plan of another state 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
- (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 BCBSIL or another BlueCross and BlueShield Plan or BlueCross 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 BCBSIL or another BlueCross and BlueShield Plan or BlueCross 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.

**CLAIM**.....means notification in a form acceptable to BCBSIL or CVS Caremark (as applicable) that a service has been rendered or furnished to you. This notification must include full details of the service and/or product received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service/product rendered or furnished, the date of service, the diagnosis (in the case of medical claims), the Claim Charge (in the case of medical claims), and any other information which BCBSIL or CVS Caremark (as applicable) may request in connection with the service/product rendered or furnished to you.

**CLAIM CHARGE**.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between BCBSIL and a particular Provider. (See provisions of this Benefit Schedule regarding "BCBSIL's Separate Financial Arrangements with Providers.")

**CLAIM PAYMENT**.....means the benefit payment calculated by BCBSIL or CVS Caremark (as applicable), after submission of a Claim, in accordance with the benefits described in this Benefit Schedule. 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 applicable Claims Administrator and a particular Provider.

**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 BCBSIL or another BlueCross and BlueShield Plan or BlueCross Plan of another state 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 BCBSIL or another BlueCross and BlueShield Plan or BlueCross Plan of another state to provide services to you at the time services are rendered.

**CLINICAL PROFESSIONAL COUNSELOR**.....means a duly licensed clinical professional counselor.

A "**Participating Clinical Professional Counselor**" means a Clinical Professional Counselor who has a written agreement with BlueCross and BlueShield of Illinois or another BlueCross and BlueShield Plan or BlueCross 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 BlueCross and BlueShield of Illinois or another BlueCross and BlueShield Plan or BlueCross Plan to provide services to you at the time services are rendered.

**CLINICAL SOCIAL WORKER**.....means a duly licensed clinical social worker.

A "**Participating Clinical Social Worker**" means a Clinical Social Worker who has a written agreement with BlueCross and BlueShield of Illinois or another BlueCross and BlueShield Plan or BlueCross 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 BlueCross and BlueShield of Illinois or another BlueCross and BlueShield Plan or BlueCross Plan to provide services to you at the time services are rendered.

**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.

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

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

**COVERAGE DATE**.....means the date on which your coverage under the Medical Plan begins.

**COVERAGE TIER**.....means the coverage option you have selected for yourself and, if applicable, your eligible Dependent(s). The Coverage Tiers offered under this Plan are:

**Employee Only Coverage** (also known as **Individual Coverage**) means that the Plan will pay only your own expenses for Covered Services, and will not pay the expenses of other members of your family.

**Employee Plus Spouse Coverage** means that the Plan will pay for the Covered Services of only you and your spouse, and will not pay the expenses for any other members of your family.

**Employee Plus Child(ren) Coverage** means that the Plan will pay for the Covered Services of only you and your enrolled child(ren), and will not pay the expenses for any other members of your family.

**Family Coverage** means that the Plan will pay for the Covered Services of you and your enrolled Dependents.

**COVERED SERVICE**.....means a service and supply specified in this Benefit Schedule for which benefits will be provided.

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

A **“Participating CRNA”** means a CRNA who has a written agreement with BCBSIL or a BlueCross and BlueShield Plan or BlueCross Plan of another state to provide services to you at the time services are rendered.

A **“Non-Participating CRNA”** means a CRNA who does not have a written agreement with BCBSIL or a BlueCross and BlueShield Plan or BlueCross Plan of another state to provide services to you at the time services are rendered.

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

**DEDUCTIBLE**.....means the amount of eligible Claim dollars you must incur for Covered Services each Benefit Period before benefits will be paid. In other words, after you have had Claims for \$2,700 of Covered Services in a Benefit Period, your benefits will begin. This Deductible will be referred to as the program Deductible.

If you have Family Coverage (or Employee Plus Spouse Coverage or Employee Plus Child(ren) Coverage), and you and your Covered Dependents have reached the program Deductible amount of \$5,450, it will not be necessary for anyone else in your family to meet a program Deductible in that Benefit Period. That is, for the remainder of the Benefit Period, neither you nor your Covered Dependents are required to meet a program Deductible before receiving benefits. An individual family member who is covered as part of Family Coverage (or Employee Plus Spouse Coverage or Employee Plus Child(ren) Coverage) may not apply more than the individual program Deductible amount toward the family program Deductible.

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

**DENTIST**.....means a duly licensed dentist.

**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 and electromyograms.

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

**DURABLE MEDICAL EQUIPMENT PROVIDER**.....means a duly licensed durable medical equipment provider.

A “**Participating Durable Medical Equipment Provider**” means a Durable Medical Equipment Provider who has a written agreement with BCBSIL or another BlueCross and BlueShield Plan or BlueCross 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 BCBSIL or another BlueCross and BlueShield Plan or BlueCross Plan to provide services to you at the time services are rendered.

**ELIGIBLE CHARGE**.....means (a) in the case of a Provider which has a written agreement with BCBSIL to provide care to you at the time Covered Services are rendered, such Provider’s Claim Charge for Covered Services, and (b) in the case of a Provider which does not have a written agreement with BCBSIL to provide care to you at the time Covered Services are rendered, the amount for Covered Services as determined by BCBSIL based on the following order:

- (i) The charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by BCBSIL, if available,
- (ii) The amount that the Centers for Medicare & Medicaid Services (“CMS”) reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program, or
- (iii) The charge which the particular Hospital or facility usually charges its patients for Covered Services.

**ELIGIBLE PERSON**.....means an Eligible Disabled Person or an Eligible Employee of an Employer as defined in the Wrap Around Plan Document of the Medical Plan.

**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 the sudden and unexpected onset of a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences.

Examples of medical conditions are: severe chest pains, convulsions or persistent severe abdominal pains.

**EMERGENCY MENTAL ILLNESS ADMISSION**....means an admission for the treatment of Mental Illness as a result of the sudden and unexpected onset of a mental condition that the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

Examples of Mental Illness are: major depression with significant suicidal intent, psychosis with associated homicidal intent or a manic episode resulting in inability to care for oneself.

**EMPLOYER**.....has the meaning set forth in the Wrap Around Plan Document of the Medical Plan.

**FAMILY COVERAGE**..... SEE DEFINITION OF COVERAGE TIER.

**FORMULARY DRUG LIST**.....means a list of preferred brand drugs that are selected for inclusion on the list based on their ability to meet patient needs at a lower cost; the Formulary Drug List does not guarantee coverage.

**GENERIC DRUG**.....means a Prescription Drug which is not trademarked but is chemically equivalent to a Brand Name Drug.

**HEARING AID DEALER**.....means a Provider licensed to make and provide hearing aids to you.

**HOME INFUSION THERAPY PROVIDER**.....means a duly licensed home infusion therapy provider.

A “**Participating Home Infusion Therapy Provider**” means a Home Infusion Therapy Provider who has a written agreement with BCBSIL or another BlueCross and BlueShield Plan or BlueCross 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 BCBSIL or another BlueCross and BlueShield Plan or BlueCross 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.

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

**HOSPITAL**.....means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, Skilled Nursing Facilities, convalescent homes, custodial homes of the aged or similar institutions.

A “**Participating Hospital**” means an Administrator Hospital that has an agreement with BCBSIL or a BlueCross and BlueShield Plan or BlueCross Plan of another state 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.

**INDIVIDUAL COVERAGE.....** SEE DEFINITION OF COVERAGE TIER.

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

**INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....**means procedures, drugs, devices, services and/or supplies which (a) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (b) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (c) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you. (For coverage purposes, this definition also refers to experimental procedures, drugs, devices, services and/or supplies.)

**LIFESTYLE DRUG.....**means Prescription Drugs that are not generally considered Medically Necessary.

**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.

**MAIL ORDER DRUG.....**means approved drugs and medicines from Caremark Mail Order Prescription Pharmacy, which provides its services to Participants or Covered Dependents under this Medical Plan.

**MAIL ORDER PHARMACY.....**means Caremark, which provides its services to Participants covered under this Medical Plan.

**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.

A “**Participating Marriage and Family Therapist**” means a Marriage and Family Therapist who has a written agreement with BCBSIL or another BlueCross and BlueShield Plan or BlueCross Plan of another state 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 BCBSIL or another BlueCross and BlueShield Plan or BlueCross Plan of another state 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 the amount determined by BCBSIL which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers, whether Participating or Non-Participating will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by BCBSIL.

**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 SCHEDULE.

**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 HEALTH UNIT**.....means a unit established to perform preadmission review and length of stay review for Inpatient and/or Outpatient services for the treatment of Mental Illness and Substance Abuse.

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

**NETWORK RETAIL PHARMACY**.....means a Pharmacy or drug store which has entered into a service agreement with Caremark to provide benefits under the Medical Plan at specified rates to persons covered under the Medical Plan.

**NON-FORMULARY DRUG**.... SEE DEFINITION OF FORMULARY DRUG LIST.

**NON-NETWORK RETAIL PHARMACY**.....means a Pharmacy or drug store which has not entered into a service agreement with Caremark to provide benefits under the Medical Plan at specified rates to persons covered under the Medical Plan.

**NON-PARTICIPATING HOSPITAL**.....SEE DEFINITION OF HOSPITAL.

**NON-PARTICIPATING PROFESSIONAL PROVIDER**.....SEE DEFINITION OF PROVIDER.

**NON-PARTICIPATING PROVIDER**.....SEE DEFINITION OF PROVIDER.

**NON-PREFERRED BRAND DRUG**.....means a trademarked Prescription Drug that is not included on Caremark's Formulary Drug List.

**OCCUPATIONAL THERAPIST**.....means a duly licensed occupational therapist.

**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.

**OTOLOGIST**.....means a duly licensed otologist or otolaryngologist.

**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 Claims Administrator approved planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

**PARTICIPATING HOSPITAL**.....SEE DEFINITION OF HOSPITAL.

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

**PARTICIPATING PROVIDER.....**means a Professional Provider that has signed an Agreement with the Claims 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 Claims Administrator's benefit payment and the Maximum Allowance for the particular Covered Service – that is, your program Deductible, Copayment and Coinsurance amounts.

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

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

**PHYSICAL THERAPIST.....**means a duly licensed physical therapist.

**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.

**PHYSICIAN ASSISTANT.....**means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

**PODIATRIST.....**means a duly licensed podiatrist.

**PREFERRED BRAND DRUG.....** means a trademarked Prescription Drug that is included on Caremark's Formulary Drug List.

**PRESCRIPTION DRUG EXPENSE EXCLUSIONS.....**SEE EXCLUSIONS SECTION OF THIS BENEFIT SCHEDULE.

**PRESCRIPTION DRUGS.....**means:

- (i) Drugs or medicines which are prescribed by a Qualified Prescriber for the treatment of illness, injury, or pregnancy;
- (ii) Insulin, but only when prescribed in writing by a Qualified Prescriber;
- (iii) Insulin needles and syringes; and
- (iv) Contraceptive devices, implants, supplies or drugs.

**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.

**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.

**“Administrator Provider”** means a Provider which has a written agreement with BCBSIL or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to you at the time the services are rendered to you.

**“Non-Administrator Provider”** means a Provider which does not have a written agreement with BCBSIL or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to you at the time the services are rendered to you unless otherwise specified in the definition of a particular Provider.

**“Participating Provider”** means an Administrator Hospital or Professional Provider which has a written agreement with BCBSIL or a BlueCross and BlueShield Plan or BlueCross Plan of another state to provide services to Participants in the Participating Provider Option program or an Administrator facility which has been designated by BCBSIL as a Participating Provider.

**“Non-Participating Provider”** means an Administrator Hospital or Professional Provider which does not have a written agreement with BCBSIL or a BlueCross and BlueShield Plan or BlueCross Plan of another state to provide services to Participants in the Participating Provider Option program or a facility which has not been designated by BCBSIL as a Participating Provider.

**“Professional Provider”** means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider designated by BCBSIL or a BlueCross and BlueShield Plan or BlueCross Plan of another state.

**PSYCHOLOGIST**.....means a Registered Clinical Psychologist.

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 PRESCRIBER**.....means a licensed Physician, Dentist, or other health care practitioner who may, in the legal scope of his/her practice, prescribe drugs or medicines.

**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.

**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 DRUG**.....means approved drugs and medicines purchased from a retail drug store or pharmacy.

**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.

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.

**SPECIALTY/BIOTECH DRUG**.....means a type of Prescription Drug that is used in the management of chronic or genetic disorders and that is often an injectable or infused medicine. These medicines treat far more complex and typically less common conditions and require complex pharmacy management, including the appropriateness of treatment, side effect management, management of additional medicines to aid the main medicine, longer care evaluations, and discussions of disease and medicine.

**SPEECH THERAPIST**.....means a duly licensed speech therapist.

**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.

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

**SUBSTANCE ABUSE REHABILITATION TREATMENT**.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. 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 retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

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

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

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

## **IV. ELIGIBILITY SECTION**

### **A. MEDICARE ELIGIBLE COVERED PERSONS**

If you meet the definition of an Eligible Person and you are eligible for Medicare and not affected by the “Medicare Secondary Payer” (MSP) laws as described below, the benefits described in the section of this Benefit Schedule entitled “Benefits for Medicare Eligible Covered Persons” will apply to you and, depending on which Coverage Tier you have selected, to your spouse and covered dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws).

A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

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

1. GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual’s family has “current employee status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

**PLEASE NOTE: SEE YOUR EMPLOYER OR PLAN ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.**

### **B. YOUR MSP RESPONSIBILITIES**

In order to assist your Employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from BCBSIL and/or your Employer regarding the Medicare eligibility of you, your spouse and covered Dependent Children. In addition, if you, your spouse or covered Dependent Child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your Employer or your Plan Administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

### **C. YOUR ID CARD**

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

#### **D. COVERAGE TIERS**

This Plan has four separate Coverage Tiers. The benefits provided to you and your Dependent(s) depend on which Coverage Tier you have selected. The various Coverage Tiers are as follows:

- If you have **Employee Only Coverage** (also known as **Individual Coverage**), the Plan will pay only your own expenses for Covered Services, and will not pay the expenses of other members of your family.
- If you have **Employee Plus Spouse Coverage**, the Plan will pay for the Covered Services of only you and your spouse, and will not pay the expenses for any other members of your family.
- If you have **Employee Plus Child(ren) Coverage**, the Plan will pay for the Covered Services of only you and your child(ren), and will not pay the expenses for any other members of your family.
- If you have **Family Coverage**, the Plan will pay for the Covered Services of you and your enrolled Dependents.

## V. MEDICAL SERVICES ADVISORY PROGRAM

BCBSIL has established the Medical Services Advisory Program (MSA) to perform a review of the following Covered Services **prior to** such services being rendered:

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

The MSA is staffed primarily by registered nurses and other personnel with clinical backgrounds. The Physicians in our medical department are an essential part of the MSA.

The MSA's toll-free telephone number is on your BlueCross and BlueShield identification card. Please read the provisions below very carefully.

The provisions of the MSA section do not apply to the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment. The provisions for the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are specified in the MENTAL HEALTH UNIT section of this Benefit Schedule.

### A. 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 Medical Plan.**

Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must call the MSA. 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 not Medically Necessary, it will be referred to BCBSIL's Physician for review. If BCBSIL's Physician concurs that the proposed admission or health care services are not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The MSA will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

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

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

- **Maternity Admission Review**

**Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Medical Plan.**

In the event of a maternity admission, you or someone who calls on your behalf must, notify the MSA no later than two business days after the admission has occurred in order to have the Inpatient Hospital admission reviewed.

Even though you are not required to call the MSA prior to your maternity admission, if you call the MSA as soon as you find out you are pregnant, the MSA will begin to monitor your case. When you contact the MSA, you will be asked to answer a series of questions regarding your pregnancy. The MSA will provide you with educational materials which will be informative for you and which you may want to discuss with your Physician. A letter will be sent to your Physician stating that you contacted the MSA. The MSA will monitor your case and will be available should you have questions about your maternity benefits.

- **Skilled Nursing Facility Preadmission Review**

**Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Medical Plan.**

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must, call the MSA. This call must be made at least one business day prior to the scheduling of the admission. When you call the MSA, a case manager may be assigned to you for the duration of your care.

- **Coordinated Home Care Program Preadmission Review**

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

Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must, call the MSA. This call must be made at least one business day prior to the scheduling of the admission. When you call the MSA, a case manager may be assigned to you for the duration of your care.

- **Private Duty Nursing Service Review**

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

Whenever Private Duty Nursing Service is recommended by your Physician, you must, call the MSA. This call must be made at least one business day prior to receiving services. When you call the MSA, a case manager may be assigned to you for the duration of your care.

## **B. CASE MANAGEMENT**

After your case has been evaluated, you may be assigned a case manager. In some cases, if your condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan.

Alternative benefits will be provided only so long as BCBSIL determines that the alternative services are Medically Necessary and cost effective. The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Medical 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 Medical Plan.

## **C. 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 Medical Plan.**

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

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the MSA. 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 BCBSIL's Physician for review.

#### **D. MEDICALLY NECESSARY DETERMINATION**

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the MSA. Should BCBSIL's Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not in benefit. For further details regarding Medically Necessary care and other exclusions from coverage under the Medical Plan, see the section entitled, "EXCLUSIONS – WHAT IS NOT COVERED."

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

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

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

#### **E. MSA PROCEDURE**

When you contact the MSA, you should be prepared to provide the following information:

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

When you contact the MSA, the MSA:

1. Will review the medical information provided and may follow up with the Provider;
2. May refer you to a Participating Provider for service; and
3. May determine that the services to be rendered are not Medically Necessary.

#### **F. APPEAL PROCEDURE**

If you or your Physician disagree with the determination of the MSA prior to or while receiving services, you may appeal that decision by contacting the MSA or BCBSIL's Medical Director.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the MSA, 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  
Health Care Service Corporation  
P. O. Box A3957  
Chicago, Illinois 60601

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

Once you have requested this review, you may submit additional information and comments on your Claim to BCBSIL 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 pertinent documents held by BCBSIL, if you request an appointment in writing.

Within 30 days of receiving your request for review, BCBSIL 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.

#### **G. FAILURE TO NOTIFY**

The final decision regarding your course of treatment is solely your responsibility and the MSA will not interfere with your relationship with any Provider. However, BCBSIL has established the MSA for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits described in this Benefit Schedule.

#### **H. MEDICARE ELIGIBLE MEMBERS**

The provisions of this MSA section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Medical Plan.

## **VI. MENTAL HEALTH UNIT**

BCBSIL has established a Mental Health Unit to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Abuse. The Mental Health Unit is staffed primarily by Physicians, Psychologists, and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit will result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, seven (7) days a week at the toll-free number 1-800-851-7498. Read the provisions below very carefully.

### **A. 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 Medical Plan.**

Whenever a nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Abuse is recommended by your Physician, you must, in order to receive maximum benefits described in this Benefit Schedule, call the Mental Health Unit at the customer service number listed on the back of your ID card. This call must be made at least one day prior to the Hospital admission.

If the proposed Hospital admission does not meet the criteria for Medically Necessary care, it will be referred to a Physician in the Mental Health Unit. If the Mental Health Unit Physician concurs that the proposed admission does not meet the criteria for Medically Necessary care, some days or the entire hospitalization will be denied. Your Physician and the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Mental Illness Admission Review**

**Emergency Mental Illness 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 Medical Plan.**

In the event of an Emergency Mental Illness Admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Benefit Schedule, notify the Mental Health Unit no later than 48 hours or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **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 Medical Plan.**

Whenever an admission to a Partial Hospitalization Treatment Program is recommended by your Physician, you must, in order to receive maximum benefits described in this Benefit Schedule, call the Mental Health Unit. This call must be made at least one day prior to the admission.

- **Length of Stay Review**

**Length of stay 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 Medical Plan.**

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

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Mental 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 Mental Health Unit Physician for review.

## **B. MEDICALLY NECESSARY DETERMINATION**

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Mental Health Unit. Should the Mental Health Unit Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not in benefit. For further details regarding Medically Necessary care and other exclusions described in this Benefit Schedule, see the section entitled, ‘EXCLUSIONS – WHAT IS NOT COVERED.’

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

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

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

## **C. MENTAL HEALTH UNIT PROCEDURE**

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

1. The name of the attending and/or admitting Provider;
2. The name of the Hospital or facility where the admission and/or service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit, the Mental Health Unit:

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

## **D. APPEAL PROCEDURE**

### **Expedited Appeal**

If you or your Physician disagree with the determinations of the Mental Health Unit prior to or while receiving services, you or the Provider may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Provider will be notified of the Mental Health Unit Physician’s determination within twenty-four (24) hours or no later than the last authorized day. If you or your Provider still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

## **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 Mental Health Unit, 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:

BlueCross and BlueShield of Illinois  
Appeals Coordinator  
BlueCross and BlueShield Mental Health Unit  
P. O. Box 805107  
Chicago, Illinois 60680-4112

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

Once you have requested this review, you may submit additional information and comments on your Claim to BCBSIL 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 pertinent documents held by BCBSIL, if you request an appointment in writing.

Within 30 days of receiving your request for review, BCBSIL 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.

### **E. FAILURE TO NOTIFY**

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

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

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

Alternative benefits will be provided only so long as BCBSIL 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 Medical 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 or exclusions of the Medical Plan.

### **G. MEDICARE ELIGIBLE MEMBERS**

The provisions of the MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Medical Plan.

## **VII. THE PARTICIPATING PROVIDER OPTION**

Your Employer has chosen the BCBSIL “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.

A directory of Participating Hospitals is available on the BCBSIL website or by calling the customer service number on the back of your ID card. While there may be changes in the directory from time to time, selection of Participating Hospitals by BCBSIL will continue to be based upon the range of services, geographic location and cost-effectiveness of care. 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.

## **VIII. 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 Schedule 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 Schedule. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Benefit Schedule 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 the particular Coverage Tier that you selected.

### **A. 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 BCBSIL.

#### **Coordinated Home Care**

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

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

#### **Participating Provider**

Benefits will be provided at 100% of the Hospital's Eligible Charge when you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider after you have met your program Deductible. 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.

#### **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 60% of the Eligible Charge, after you have met your program Deductible. 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.

### **C. 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. Shock therapy treatments
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. Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible
8. Emergency Medical Care
9. Mammograms—Benefits for routine mammograms will be provided at the benefit payment described in the Wellness Care provision of this Benefit Schedule. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.
10. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females at the benefit payment described in the Wellness Care provision of this Benefit Schedule.
11. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment described in the Wellness Care provision of this Benefit Schedule.
12. Bone Mass Measurement—Benefits for bone mass measurement will be provided at the benefit payment described in the Wellness Care provision of this Benefit Schedule.
13. Diagnosis and Treatment of Osteoporosis
14. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this Benefit Schedule. Benefits for surgical procedures in connection with screening procedures, such as colonoscopy and sigmoidoscopy, will be provided at the benefit payment level for Surgery described in this Benefit Schedule.

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

#### **Participating Provider**

Benefits will be provided at 100% of the Eligible Charge after you have met your program Deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

#### **Non-Participating Provider**

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge, after you have met your program Deductible.

**Emergency Accident Care**

Benefits for Emergency Accident Care will be provided at 100% of the Eligible Charge subject to Deductible when you receive Covered Services from either a Participating or Non-Participating Provider.

Benefits for Emergency Medical Care will be provided at 100% of the Eligible Charge subject to Deductible when you receive Covered Services from either a Participating or Non-Participating Provider.

**E. BENEFIT PAYMENT FOR HOSPITAL COVERED SERVICES WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)**

If you must receive Hospital Covered Services that BCBSIL has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider may be provided at the payment level described for a Participating Provider. Coverage will be subject to pre-approval by BCBSIL.

## **IX. PHYSICIAN BENEFIT SECTION**

This section of your Benefit Schedule 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 Schedule. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Benefit Schedule 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 the particular Coverage Tier that you selected.

### **A. SURGICAL-RELATED 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 Medical Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

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

The following services are also part of your surgical benefits:

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

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

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

### **Additional Surgical Opinion**

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge and will not be subject to the program Deductible. 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.

### **B. MEDICAL CARE VISITS**

Benefits are available for Medical Care visits when:

1. You are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Abuse Treatment Facility 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.

No benefits are available under this benefit section for the treatment of Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section of this Benefit Schedule.

### **C. CONSULTATIONS**

Your coverage includes benefits for consultations when you are an Inpatient in a Hospital or Skilled Nursing Facility. The consultation must be requested by your attending 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 renders Surgery or Maternity Service during the same admission.

### **D. DIABETES SELF-MANAGEMENT TRAINING AND EDUCATION**

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this Section IX. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in Section X of this Benefit Schedule.

### **E. OTHER COVERED SERVICES IN THE PHYSICIAN BENEFIT SECTION**

**Allergy injections and allergy surveys**

**Bariatric Surgery/Gastric Bypass**

**Bone Mass Measurement and Osteoporosis Diagnosis/Treatment**—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis. Coverage is also provided under the Wellness Care Program provision of this Benefit Schedule.

**Chemotherapy**

**Chiropractic and Osteopathic Manipulation**—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of \$2,000 per Benefit Period.

**Colorectal Cancer Screening**—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this Benefit Schedule. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this Benefit Schedule.

**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.

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

**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.

**Emergency Accident Care**—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

#### **Emergency Medical Care**

**Foot Care Examinations**—Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

**Mammograms** —Benefits for routine mammograms will be provided at the benefit payment described in the Wellness Care provision of this Benefit Schedule. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.

**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 will be limited to a maximum of \$5,000 per Benefit Period.

**Pap Smear Test**—Benefits will be provided for an annual routine cervical smear or Pap smear test for females at the benefit payment described in the Wellness Care provision of this Benefit Schedule.

**Physical Therapy**—Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of \$5,000 per Benefit Period; however, Physical Therapy necessitated by congenital defects, birth abnormalities, or developmental growth abnormalities (e.g., cerebral palsy) is not subject to the \$5000 maximum benefit cap.

**Prostate Test and Digital Rectal Examination**—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment described in the Wellness Care provision of this Benefit Schedule.

#### **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 will be limited to a maximum of \$5,000 per Benefit Period; however, Outpatient Speech Therapy necessitated by congenital defects, birth abnormalities, or developmental growth abnormalities (e.g., cerebral palsy) is not subject to the \$5000 maximum benefit cap.

#### **Shock therapy treatments**

#### **Therapeutic Abortions**

### **F. BENEFIT PAYMENT FOR PHYSICIAN SERVICES**

The benefits provided by BCBSIL and the expenses that are your responsibility for your Covered Services in this Physician Benefit Section will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

#### **Participating Provider**

Benefits will be provided at 100% of the Maximum Allowance after you have met your program Deductible when you receive any of the Covered Services described in this Physician benefit section from a Participating Provider or from a Dentist. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this Medical Plan and may bill you for the difference between BCBSIL's benefit payment and the Provider's charge to you.

#### **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 60% of the Maximum Allowance, after you have met your program Deductible, unless specifically mentioned below.

#### **Participating and Non-Participating Provider**

Benefits for Emergency Accident Care will be provided at 100% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider; after you have met your program Deductible.

Benefits for Emergency Medical Care will be provided at 100% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider; after you have met your program Deductible.

## **X. OTHER COVERED SERVICES**

### **A. OTHER COVERED SERVICES**

This section of your Benefit Schedule describes various other Covered Services under this Medical Plan and the benefits that will be provided for them.

- Blood and blood components
- Leg, back, arm and neck braces
- 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. Precertification is required. 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
- Prosthetic appliances—Benefits will be provided for prosthetic devices, special appliances and surgical implants when:
  - a. They are required to replace all or part of an organ or tissue of the human body, or
  - b. They are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

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).

- Optometric services—Benefits will be provided for services which may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician.
- Eyeglasses/Contacts—Benefits will be provided for the first pair of eyeglasses or contacts immediately after cataract surgery.
- Wigs—Benefits will be provided for wigs needed as a result of illness, treatment of illness or accidental injury. Benefits will be limited to a lifetime maximum of \$500.

### **B. BENEFIT PAYMENT FOR OTHER COVERED SERVICES**

**After you have met your program Deductible, benefits will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance for any of the Covered Services described in this section.**

**However, when you receive Covered Services described in this section from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge or 60% of the Maximum Allowance.**

## **XI. 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:

### **A. HUMAN ORGAN TRANSPLANTS**

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

- 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 Schedule 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 Schedule 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 BCBSIL by telephone before your transplant Surgery has been scheduled. BCBSIL will furnish you with the names of Hospitals which have Claims 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 Claims Administrator approved Human Organ Transplant Program.**
- If you are the recipient of the transplant, benefits will be provided for transportation, lodging and meals for you and a companion. If the recipient of the transplant is a Dependent Child under the limiting age of this Benefit Schedule, benefits for transportation, lodging and meals 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.
  - You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of \$200 per day.
  - Benefits for transportation, lodging and meals are limited to a lifetime maximum of \$10,000.
- In addition to the other exclusions of this Benefit Schedule, benefits will not be provided for:
  - 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.

## **B. BENEFIT PAYMENT FOR HUMAN ORGAN TRANSPLANT SERVICES**

### Blue Quality Centers for Transplant

Benefits will be provided at 100% of the Eligible Charge when you receive Covered Services from a BQCT. Benefits will not be subject to the program Deductible.

### Participating Provider

When you receive Covered Services from a Participating Provider, benefits will be provided at 100% of the Eligible Charge, after you have met your program Deductible.

### Non-Participating Provider

No benefits are provided if you receive Covered Services from a Non-Participating Provider.

## **C. 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 Claims Administrator approved programs when these services are rendered to you within a six-month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery or percutaneous transluminal coronary angioplasty. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six-month period.

## **D. WELLNESS CARE**

Benefits will be provided for Covered Services rendered to you, even though you are not ill. When you receive Covered Services for wellness care from a Participating Provider or Non-Participating Provider, benefits will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program Deductible.

### Wellness Benefits Limited to the \$750 maximum per Benefit Period

Certain wellness care benefits will be limited to a maximum benefit of \$750 per Benefit Period. Benefits will be limited to the following services:

1. Routine physical examination;
2. Routine gynecological examination – one per Benefit Period;
3. Routine diagnostic tests;
4. Routine eye examinations; and
5. Routine hearing examinations.

Additional preventive services in excess of \$750 for the above services are not covered.

### Wellness Benefits Not Limited to the \$750 maximum per Benefit Period

Certain other wellness services are covered under wellness care and are not subject to the wellness care maximum:

1. Routine sigmoidoscopy;
2. Routine colonoscopy;
3. Bone mineral density tests; and
4. Immunizations (immunizations for foreign travel are not covered).

## **E. 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 100% of the Eligible Charge after you have met your program Deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 60% of the Eligible Charge, once you have met your program Deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

#### **F. AMBULATORY SURGICAL FACILITY**

Benefits for all of the Covered Services previously described in this Benefit Schedule 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 100% of the Eligible Charge. Benefits for services by a Non-Administrator Ambulatory Surgical Facility will be provided at 60% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program Deductible.

#### **G. SUBSTANCE ABUSE REHABILITATION TREATMENT**

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

#### **H. MENTAL ILLNESS SERVICES**

Benefits for all of the Covered Services previously described in this Benefit Schedule 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 (1) a Physician; (2) a Psychologist, Clinical Social Worker or Clinical Professional Counselor; or (3) a Marriage and Family Therapist working within the scope of their license.

##### ***Benefit Payment for Outpatient Mental Illness and Substance Abuse Rehabilitation Treatment***

Benefits for Outpatient **Mental Illness** treatment will be provided at 100% of the Eligible Charge or at 100% of the Maximum Allowance 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 60% of the Eligible Charge or 60% of the Maximum Allowance after you have met your program Deductible.

Benefits for Outpatient **Substance Abuse** Rehabilitation Treatment (in a program approved by BCBSIL) will be provided at 100% of the Eligible Charge or at 100% of the Maximum Allowance 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 Abuse Rehabilitation Treatment, benefits will be provided at 60% of the Eligible Charge or 60% of the Maximum Allowance after you have met your program Deductible.

##### ***Benefit Maximum for Outpatient treatment of Mental Illness***

Your benefits for Outpatient treatment of Mental Illness are limited to a maximum of 45 visits per Benefit Period.

*Benefit Payment for Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment*

Benefits for the Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at the payment levels previously described in this Benefit Schedule for Hospital and Physician Covered Services.

*Benefit Maximum for Inpatient treatment of Mental Illness*

You are entitled to a maximum of 30 Inpatient Hospital days each Benefit Period for Inpatient treatment of Mental Illness.

*Benefit Maximum for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment*

Your benefits for Inpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of \$10,000 each Benefit Period.

*Lifetime Benefit Maximum for Substance Abuse Rehabilitation Treatment*

A combined lifetime maximum of \$20,000 will apply to benefits for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment.

None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment will be included in the calculation of your out-of-pocket expenses.

**I. MATERNITY SERVICE**

Your benefits for Maternity Service are the same as your benefits for any other condition, and such benefits are available regardless of which Coverage Tier you have selected. 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 if you have Employee Plus Child(ren) Coverage or Family Coverage. You must apply for Employee Plus Child(ren) Coverage or Family Coverage within 31 days of date of the birth. Your Employee Plus Child(ren) Coverage or Family Coverage will then be effective from the date of the birth.)

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

**J. TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS**

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

Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of \$2,500.

## **K. MASTECTOMY - RELATED SERVICES**

Benefits for Covered Services related to mastectomies, including, but not limited to: (a) reconstruction of the breast on which the mastectomy has been performed; (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) post mastectomy care for inpatient treatment for a length of time determined by the attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation, and a follow-up Physician office visit or in-home nurse visit within forty-eight (48) hours after discharge; and (d) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas, are the same as for any other condition.

## **L. PAYMENT PROVISIONS**

### Lifetime Maximum

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

### Cumulative Benefit Maximums

All benefits payable under this Benefit Schedule are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service, BCBSIL will include benefit payments under both this and/or any prior or subsequent Claims Administrator's Benefit Schedule issued to you as an Eligible Person or a Dependent of an Eligible Person under this plan.

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

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) equal \$2,700, 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 Participating Provider program Deductible
- 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 life threatening)

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

- Charges that exceed the Eligible Charge or Maximum Allowance
- Charges for Covered Services received for the treatment of Mental Illness and/or Substance Abuse Rehabilitation Treatment
- Copayments resulting from noncompliance with the provisions of the MSA and/or BCBSIL's Mental Health Unit
- Any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's Benefit Period, if not completed.
- Copayments for office and urgent care visits
- Prescription Drug Copayments

If you have Family Coverage or Employee Plus Spouse Coverage or Employee Plus Child(ren) Coverage, and your covered family members' out-of-pocket expenses (the amount remaining unpaid for Covered Services after benefits have been provided) equal \$5,450 during one Benefit Period, then, for the rest of the Benefit Period, all other covered family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage or Employee Plus Spouse Coverage or Employee Plus Child(ren) Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

*For Non-Participating Providers*

If, during one Benefit Period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equal \$5,400, 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 Non-Participating Provider program Deductible
- 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 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 you may receive from a Participating Provider
- The Coinsurance resulting from Hospital services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility for Covered Services
- Charges for Covered Services which have a separate dollar maximum specifically mentioned in this Benefit Schedule
- Charges for Covered Services received for the treatment of Mental Illness and/or Substance Abuse Rehabilitation Treatment
- Copayments resulting from noncompliance with the provisions of the MSA and/or BCBSIL's Mental Health Unit
- Any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's Benefit Period
- Prescription Drug Copayments

If you have Family Coverage or Employee Plus Spouse Coverage or Employee Plus Child(ren) Coverage, and your covered family members' out-of-pocket expenses (the amount remaining unpaid for Covered Services after benefits have been provided) equal \$10,900 during one Benefit Period, then, for the rest of the Benefit Period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage or Employee Plus Spouse Coverage or Employee Plus Child(ren) Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

**N. 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 Abuse Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your Benefit Period, whichever occurs first.

## **XII. HEARING CARE PROGRAM**

Your coverage includes benefits for hearing care when you receive such care from a Physician, Otolologist, Audiologist or Hearing Aid Dealer.

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

For hearing care benefits to be available, such care must be Medically Necessary and you must receive such care on or after your Coverage Date.

### **A. COVERED SERVICES**

Benefits will be provided under this benefit section for the following:

1. Audiometric Examination.
2. Hearing Aid Evaluation.
3. Conformity Evaluation.
4. Hearing Aids.

Benefits will be limited to one Covered Service(s) of each type listed above per Benefit Period.

### **B. SPECIAL LIMITATIONS**

Benefits will not be provided for the following:

1. Audiometric examinations by an Audiologist when not ordered by your Physician within 6 months of such examination.
2. Medical or surgical treatment.
3. Drugs or other medications.
4. Replacement for lost or broken hearing aids, except if otherwise eligible under frequency limitations.
5. Hearing aids ordered while covered but delivered more than 60 days after termination.

### **C. BENEFIT PAYMENT FOR HEARING CARE**

Benefits for hearing care Covered Services will be provided at 100% of the Usual and Customary Fee.

Benefits for hearing aids will be provided up to a maximum of \$1,500 per covered person every three years. Maximum includes hearing aid exam and fitting.

For purposes of this benefit section only, the definition of Usual and Customary Fee shall read as follows:

USUAL AND CUSTOMARY FEE .....means the fee as reasonably determined by BCBSIL, which is based on the fee which the Physician, Otolologist, Audiologist or Hearing Aid Dealer who renders the particular service usually charges his patients or customers for the same service and the fee which is within the range of usual fees other Physicians, Otolologists, Audiologists or Hearing Aid Dealers of similar training and experience in the same geographic area charge their patients or customers for the same service, under similar or comparable circumstances.

### **XIII. 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 Schedule.

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

#### **XIV. INFERTILITY COVERAGE**

Infertility treatment is limited to tests for fertility and procedures for correction of infertility including artificial insemination. No coverage will be provided for in vitro fertilization, GIFT, ZIFT, etc.

## **XV. BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS**

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this Benefit Schedule (see provisions entitled “Medicare Eligible Covered Persons” in the ELIGIBILITY SECTION of this Benefit Schedule).

The benefits and provisions described throughout this Benefit Schedule apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Medical Plan is as follows:

1. Determine what the payment for a Covered Service would be following the payment provisions of this coverage; and
2. Deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Medical Plan.

When you have a Claim, you must send BCBSIL a copy of your Explanation of Medicare Benefits (“EOMB”) in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

## **XVI. PRESCRIPTION DRUG EXPENSE BENEFIT**

This section of your Benefit Schedule describes your benefits for prescription drug expenses. Your prescription drug benefits are administered by CVS Caremark, Inc.

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

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

### **RETAIL DRUG EXPENSE**

The Retail Drug expense portion of the Medical Plan’s Consumer Choice Option allows you to receive benefits for a short-term supply (up to a 30-day supply) of eligible Prescription Drugs. In addition, a 90-day supply may be purchased at certain Caremark Network Retail Pharmacies.

You must pay 100% of the cost of your eligible Prescription Drugs until you have satisfied your Deductible. Once you have satisfied your Deductible, the Medical Plan will pay 100% of the cost of your eligible Prescription Drugs obtained at a Caremark Network Retail Pharmacy, and 60% of the cost of your eligible Prescription Drugs obtained at a Non-Network Retail Pharmacy. The difference between what the Medical Plan pays and what you must pay for your eligible Prescription Drugs is your Coinsurance.

Caremark Network Retail Pharmacy: You may choose to use any retail Pharmacy you wish. If you use a Network Retail Pharmacy and present your ID card, you will pay the amounts noted above and the Pharmacy will file the claim for you. If you fail to present your ID card, you may be required to pay the full cost of the prescription and file a claim with Caremark for reimbursement of covered expenses within 12 months of purchase. You will then receive the Network Retail Pharmacy reimbursement percentage of the cost of your eligible Prescription Drugs.

Non-Network Retail Pharmacy: As noted above, you are free to use any retail Pharmacy you wish. However, if you decide to use a Non-Network Retail Pharmacy (i.e., a retail Pharmacy that is not part of the Caremark network), you must pay the full cost of the prescription and file a claim with Caremark for reimbursement of covered expenses within 12 months of purchase. You will receive the Non-Network Retail Pharmacy reimbursement percentage of the cost of your eligible Prescription Drugs.

### **MAIL ORDER DRUG EXPENSE**

The Mail Order Drug expense portion of the Medical Plan’s Consumer Choice Option allows you to receive benefits for up to a 90-day supply of eligible Prescription Drugs with refills available for up to one year. Generally, if you use maintenance medication, you are encouraged to use the mail order provision.

As noted above, you must pay 100% of the cost of your eligible Prescription Drugs until you have satisfied your Deductible. Once you have satisfied your Deductible, the Medical Plan will pay 100% of the cost of your eligible Mail Order Drugs that are purchased through the Mail Order Pharmacy.

### **LIFESTYLE DRUGS**

The Medical Plan provides no coverage and will pay no benefits for Lifestyle Drugs. You must pay 100% of the cost for Lifestyle Drugs. If you order Lifestyle Drugs through the Mail Order Pharmacy, you will receive Caremark’s discounted price. However, the cost of the Lifestyle Drugs will not be applied to your Deductible or out-of-pocket expense limit.

## **XVII. 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 BCBSIL, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of BCBSIL, 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 BCBSIL, 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 setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

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

BCBSIL 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 Medical Plan. In most instances this decision is made by BCBSIL 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 BCBSIL 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 BCBSIL's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against BCBSIL, either at law or in equity. To initiate your appeal, you must give BCBSIL written notice of your intention to do so within 180 days after you have been notified that your Claim has been denied by writing to:

Claim Review Section  
Health Care Service Corporation  
P.O. Box 2401  
Chicago, Illinois 60690

You may furnish or submit any additional documentation which you or your Physician believe appropriate.

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

- **Abortions:** Elective abortions unless the life of the mother would be in danger if pregnancy continued or it is a result of rape or incest.
- **Blood derivatives** which are not classified as drugs in the official formularies.
- **Cancelled Office Visits:** charges for failure to keep a scheduled visit.
- **Claim Form Completion:** charges for completion of a Claim form.
- **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.
- **Custodial Care Service.**
- **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 Schedule.
- **Duplicate Services:** Services and supplies to the extent benefits are duplicated because the spouse, parent and/or Child are covered separately under this Medical Plan.
- **Employment Related Injuries:** 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.
- **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 for first pair of eyeglasses or contacts immediately following cataract surgery.
- **Flat foot conditions:** Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- **Free Services:** 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.
- **Government Services:** 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 payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 w 1-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- **Hearing aids** or examinations for the prescription or fitting of hearing aids except as specifically covered in this Benefit Schedule.
- **Immunizations,** unless otherwise specified in this Benefit Schedule.
- **Infertility:** Services and supplies rendered or provided for the diagnosis and/or treatment of infertility (except as expressly covered in Section XIV) including, but not limited to, gamete intra-fallopian transfer (GIFT), Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, and all forms of in-vitro fertilization.
- **Inpatient Private Duty Nursing Service.**

- **Inpatient stay:** 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.
- **Investigational Services and Supplies** and all related services and supplies, other than the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under the Benefit Schedule if not provided in connection with an approved clinical trial program.
- **Long Term Care Service.**
- **Maintenance Care.**
- **Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.**
- **“Non-Accepted Standards”:** Services or supplies that do not meet accepted standards of medical and/or dental practice.
- **“Not Specifically Mentioned”:** Services or supplies that are not specifically mentioned in this Benefit Schedule.
- **Organ or Tissue Transplants:** Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Benefit Schedule.
- **Personal hygiene, comfort or convenience items** commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- **Prescription Drug Expenses** which satisfy any of the following conditions are excluded from coverage by Caremark under the prescription benefit program; however, such items may or may not be covered benefits under the medical portion of the Plan administered by BCBSIL:
  - Drugs or medicines that are purchased after the date the Participant’s coverage under the Medical Plan has ceased, for any reason. This is true even though the expenses relate to a condition which began while the Participant was still covered.
  - Any substance, except insulin, which may be lawfully obtained without a prescription.
  - Administration of any prescription drug, insulin, or other substance.
  - Any prescription refill in excess of that specified by the Qualified Prescriber or dispensed more than 12 months after it was prescribed.
  - More than a 90-day supply of any one prescription.
  - Any investigational or experimental drug or any drug which may not lawfully be dispensed in the United States.
  - Any medication to be taken by, or administered to, a person while he/she is a patient at a Hospital, convalescent hospital, or other health care facility which itself operates, or allows to be operated on its premises, a Pharmacy or other facility for dispensing drugs.
  - Any therapeutic device or appliance, support garments, or prostheses (except following a mastectomy), regardless of the item’s intended use.
  - Drugs or medicines for which a Participant is not required to pay.
  - Drugs or medicines for which benefits are provided under any other provisions of the Medical Plan.
  - Non-legend drugs or medicines.
  - Drugs or medicines delivered or administered by the Qualified Prescriber.
  - Obsolete drugs or medicines. (Obsolete drugs or medicines are those drugs or medicines which are no longer produced or have been taken off the market by the manufacturer.)
  - Unit dose drugs or medicines. (Unit dose drugs or medicines are those drugs or medicines which are individually packaged when the same drug or medicine is available in a multi-dose container.)

- Any immunization agent, biological serum, blood, or blood plasma.
- Food supplements.
- Immunosuppressants.
- Growth hormones.
- Drugs or medicines which are experimental and/or investigational, or which are prescribed or administered for off-label use.
- **Prosthetic devices, special appliances and surgical implants:** 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.
- **Respite Care Service,** except as specifically mentioned under the Hospice Program.
- **Routine foot care,** except for persons diagnosed with diabetes.
- **Routine physical examinations,** unless otherwise specified in this Benefit Schedule.
- **Specialized equipment:** Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this Benefit Schedule.
- **Speech Therapy** when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.
- **Sterilization reversals.**
- **War:** Services or supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

## **XVIII. 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 insure that you receive all of the coverage to which you are entitled under this Medical Plan. In other words, the total payment from all of your coverages together will never be less than what would have been paid under this Medical Plan if no other group coverages were involved. It is your obligation to notify the applicable Claims Administrator (i.e., BCBSIL or CVS Caremark) of the existence of such other group coverages.

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 Participant (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. The person claiming benefits has the obligation to notify the applicable Claims Administrator, and, upon 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 rules (1) or (2) 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.

4. In order to prevent duplicate payment of benefits for a Claim, the applicable Claims Administrator uses the following process to determine benefits when it is the secondary payor:

— Determines what the payment for service would be following the payment provisions of this coverage; and

— Deducts from this resulting amount the amount paid by the primary payor. The difference is the amount that will be paid under this coverage.

The applicable Claims 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 applicable Claims Administrator have been made by such other organization under any other group program.

— Recover any overpayment which the applicable Claims Administrator may have made to you, any Provider, insurance company, person or other organization.

## **XIX. MISCELLANEOUS PLAN PROVISIONS**

### **A. BCBSIL'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS**

BCBSIL 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 BCBSIL is a party, including all persons covered under the Medical Plan. Under certain circumstances described in its contracts with Administrator Providers, BCBSIL may:

- Receive substantial payments from Administrator Providers with respect to services rendered to you for which BCBSIL 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 BCBSIL’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 BCBSIL as described in this Benefit Schedule and the calculation of all required Deductible and Coinsurance amounts payable by you as described in this Benefit Schedule shall be based on the Eligible Charge or Provider’s Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage (“ADP”) applicable to your Claim or Claims. Your Employer has been advised that BCBSIL may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and BCBSIL. Neither the 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 BCBSIL’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 Schedule.
- 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, BCBSIL will satisfy its portion of the Hospital bill. In most cases, BCBSIL has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money BCBSIL 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 BCBSIL has to satisfy the rest of the Hospital bill, or \$860. Assuming BCBSIL has a contract with the Hospital, BCBSIL 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. BCBSIL receives, and keeps for its own account, the difference between the \$860 bill and whatever BCBSIL ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

## **Other BlueCross and BlueShields' Separate Financial Arrangements with Providers**

### BlueCard

BCBSIL hereby informs you that other BlueCross and BlueShield Plans outside of Illinois (“Host Blue”) may have contracts similar to the contracts described above with certain Providers (“Host Blue Providers”) in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with BCBSIL, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to BCBSIL.
  - a. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by BCBSIL.
  - 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 BCBSIL and indicates that the negotiated price for the covered service is \$80. BCBSIL 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 Schedule.

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

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

### Servicing Plans

In some instances, BCBSIL has entered into agreements with other BlueCross and BlueShield Plans (“Servicing Plans”) to provide, on BCBSIL’s behalf, Claim Payments and certain administrative services for you. Under these agreements, BCBSIL will reimburse each Servicing Plan for all Claim Payments made on BCBSIL’s behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers (“Servicing Plan Providers”) in their service area. The Servicing Plan will process your Claim in accordance with the Servicing Plan’s applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by BCBSIL for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required Deductible and Coinsurance amounts under this Medical Plan will be calculated on the basis of the Servicing Plan Provider’s Eligible Charge for Covered Services rendered to you or the cost agreed upon between the

Servicing Plan and BCBSIL for Covered Services that the Servicing Plan passes to BCBSIL, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state's statutory method.

**B. SUBMISSION OF CLAIMS, PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS**

1. All Claims for benefits under this Medical Plan must be submitted to BCBSIL within 12 months of the date of the date the medical service was provided for which you are seeking benefits. The Claims procedures under this Medical Plan are set forth in detail in the Wrap-Around Plan Document.
2. Under this Medical Plan, BCBSIL has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, BCBSIL may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. BCBSIL is specifically authorized by you to determine to whom any benefit payment should be made.
3. Once Covered Services are rendered by a Provider, you have no right to request BCBSIL not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, BCBSIL will have no liability to you or any other person because of its rejection of such request.
4. A Covered Person's Claim for benefits under this Medical Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a Covered Person. Coverage under this Medical 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 a Claim for benefits or coverage shall be null and void.

**C. YOUR PROVIDER RELATIONSHIPS**

1. The choice of a Provider is solely your choice and BCBSIL will not interfere with your relationship with any Provider.
2. BCBSIL does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. BCBSIL 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 BCBSIL. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that BCBSIL is providing professional service.
3. The use of an adjective such as Participating, Administrator 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, 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.
4. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individual Covered Person) or your Employer's Health Benefit Program.

#### **D. NOTICES**

Any information or notice which you furnish to BCBSIL under the Medical Plan as described in this Benefit Schedule must be in writing and sent to BCBSIL at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this Benefit Schedule for a specific situation). Any information or notice which BCBSIL furnishes to you must be in writing and sent to you at your address as it appears on BCBSIL'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 BCBSIL's records.

#### **E. INFORMATION AND RECORDS**

You agree that it is your responsibility to insure that any Provider, other BlueCross and BlueShield 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 Medical 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 BCBSIL or its agent, and agree that any such Provider, person or other entity may furnish to BCBSIL 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, BCBSIL may furnish similar information and records (or copies of records) to Providers, BlueCross and BlueShield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish BCBSIL and/or your Employer or Plan 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 BCBSIL be able to make Claim Payments in accordance with MSP laws.

## **XX. 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 Schedule, you agree:

1. BCBSIL has the rights to reimbursement for all benefits BCBSIL 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 BCBSIL has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.
2. BCBSIL is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits BCBSIL provided for that sickness or injury.

BCBSIL 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 BCBSIL 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 BCBSIL 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 Schedule regarding "BCBSIL's Separate Financial Arrangements with Providers.")

ASO-1

Effective Date: January 1, 2007