FARM CREDIT FOUNDATIONS

RETIREE MEDICAL PLAN

WRAP AROUND PLAN DOCUMENT
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FARM CREDIT FOUNDATIONS
RETIREE MEDICAL PLAN

PREAMBLE

This Farm Credit Foundations Medical Plan (the “Retiree Medical Plan”) is sponsored and maintained by those Farm Credit System employers that are parties to the Farm Credit Foundations Administrative Agreement Regarding Employee Benefit Plans (the “Administrative Agreement”).

Each of the Participating Employers in this Retiree Medical Plan is a member of the federal Farm Credit System as well as a party to the Administrative Agreement. These Farm Credit institutions include Farm Credit Banks, Federal Land Bank Associations, Production Credit Associations, Banks for Cooperatives, and other institutions that are chartered by and subject to regulation by the Farm Credit Administration. (12 U.S.C. § 2002(a)). The Farm Credit Banks, Production Credit Associations, and Federal Land Bank Associations are statutorily defined to be “federally chartered instrumentalities of the United States,” (12 U.S.C. §§ 2011(a), 2071(a), and 2091(a)), and the Agricultural Credit Associations, Federal Land Credit Associations, and Service Corporations are similarly defined in the charters issued to them by the Farm Credit Administration.

For this reason, the Retiree Medical Plan is intended to be a “governmental plan” as that term is defined in Code § 414(d). As a “governmental plan,” the Retiree Medical Plan is not subject to Title I of the Employee Retirement Income Security Act of 1974 (“ERISA”). In addition, the Retiree Medical Plan is not subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), although it voluntarily offers continuation coverage similar to that found in COBRA, as set forth in this Retiree Medical Plan. Because of the close relationship that exists between the employers in the Retiree Medical Plan under the provisions of the Farm Credit Act and the terms of their respective charters, and because of their status as “instrumentalities of the United States,” the Retiree Medical Plan, consistent with prior historical practice, is designed and intended to be a single-employer plan.
ARTICLE I
INTRODUCTION

Section 1.01 Purpose of Retiree Medical Plan. The purpose of the Retiree Medical Plan is to provide Eligible Retirees and their Eligible Dependents with medical benefits.

Section 1.02 Health Plan Status. The Employer intends that this Retiree Medical Plan qualify as a health plan within the meaning of Code § 105(e) and that the benefits payable under this Retiree Medical Plan be eligible for exclusion from gross income under Code § 105(b).

Section 1.03 Single Employer Plan Status. In light of this Retiree Medical Plan’s status as a “governmental plan,” it is the intent of the Employer that this Retiree Medical Plan be considered a single employer plan.

Section 1.04 Exclusive Benefit. It is intended that the Retiree Medical Plan terms, including those related to coverage and benefits, be legally enforceable and that the Retiree Medical Plan be maintained for the exclusive benefit of Eligible Retirees and their Eligible Dependents.

Section 1.05 Effect on Prior Plans. Prior to January 1, 2007, AgriBank and its affiliated associations, U.S. AgBank and its affiliated associations, Northwest Farm Credit Services, and other employers within the federal Farm Credit System that are parties to the Administrative Agreement maintained certain welfare benefit plans on a separate basis. Pursuant to the Administrative Agreement, effective January 1, 2007, these Farm Credit System employers agreed to consolidate certain employee benefit plans that were previously sponsored separately. This Retiree Medical Plan amends and restates the separate retiree medical benefit plans that were previously sponsored by these Farm Credit System employers. As part of this amendment and restatement, the name of the Retiree Medical Plan has been changed to the Farm Credit Foundations Retiree Medical Plan.

Section 1.06 Character of Benefits Provided. This Retiree Medical Plan does not provide medical treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Retiree Medical Plan. The fact that a particular medical service may not be eligible for reimbursement under this Retiree Medical Plan does not mean that a Covered Person who is covered under this Retiree Medical Plan should not receive that service.

Section 1.07 Funding Policy and Method. The medical benefits under this Retiree Medical Plan are funded by the Employer. The cost of providing these medical benefits may be paid for by Employer and Retiree contributions. The Employer, in its sole discretion, may purchase a group insurance policy to fund some or all of the benefits under this Retiree Medical Plan, but shall have no obligation to do so.
Section 1.08 Effective Date. The effective date of this Retiree Medical Plan, as amended and restated, is January 1, 2007; provided, however, that if this Retiree Medical Plan is subsequently amended, such new or amended provisions shall be effective on a later date as provided in the Plan Sponsor Committee minutes adopting such new or amended provisions or in any formal amendment adopted by the Plan Sponsor Committee.

Section 1.09 Required Forms. The Plan Administrator may require the completion and submission of any form required pursuant to this Retiree Medical Plan (e.g., enrollment forms) in electronic form through the use of the internet, an intranet, a telephone system, or such other system as the Plan Administrator may prescribe.
ARTICLE II
DEFINITIONS

This Retiree Medical Plan contains various words and phrases that are defined in either this Article II or in the definitions section of the applicable Benefit Schedule. Where the defined meaning is intended, the term is capitalized in both the Wrap Around Plan Document and the applicable Benefit Schedule.

Section 2.01 “Administrative Agreement” means the Farm Credit Foundations Administrative Agreement Regarding Employee Benefit Plans, as amended from time to time.

Section 2.02 “Age 65 and Older Coverage” means the coverage provided through Article VII of this Retiree Medical Plan.

Section 2.03 “Benefit Description” means the Benefit Description for the Farm Credit Foundations Retiree Medical Plan, which is attached to this Wrap Around Plan Document and is incorporated by reference.

Section 2.04 “Benefit Schedules” means the various Benefit Schedules for the Farm Credit Foundations Retiree Medical Plan, which are incorporated by reference and made a part of the Benefit Description. Any definitions in the Benefit Schedules are incorporated by reference as part of this Retiree Medical Plan.

Section 2.05 “Calendar Year” means the period of twelve (12) consecutive months from January 1 through December 31.

Section 2.06 “Child” or “Children” when either of such terms is used in the definition of Dependent, includes the Covered Retiree’s (or covered Domestic Partner’s) natural children, adopted children, stepchildren, foster children, or children under the Covered Retiree’s (or covered Domestic Partner’s) legal guardianship by court order.

Section 2.07 “Claims Administrator” means the company or companies (if any) which the Employer has retained, on an insured or contract administration basis, to assist in making determinations whether to grant or deny Claims for benefits under this Retiree Medical Plan. The identity of the Claims Administrator(s) is set forth in Articles X and XI of this Retiree Medical Plan.

Section 2.08 “Code” means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.09 “Covered Dependent” means an Eligible Dependent who is enrolled in this Retiree Medical Plan pursuant to Article IV.

Section 2.10 “Covered Person” means a Covered Retiree or Covered Dependent.

Section 2.11 “Covered Retiree” means an Eligible Retiree who is enrolled in this Retiree Medical Plan pursuant to Article IV.
Section 2.12 “Dependent” has the meaning set forth in the Insurance Contract for individuals who are age 65 or older and has the following meaning for individuals who are under age 65:

(A) A Retiree’s Spouse, but only if the Spouse is not divorced or legally separated from the Retiree.

(B) A Retiree’s Domestic Partner.

(C) A Retiree’s Children through the end of the month in which the Child turns age 26.

(D) A Retiree’s Children if such Children:

   (1) Are over age 26; and

   (2) Are unmarried; and

   (3) Are principally dependent upon the Retiree as their primary source of financial support at the time the Child would otherwise cease to be eligible because of age; and

   (4) Are incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap.

(E) A Domestic Partner’s Children if the Domestic Partner is enrolled in the Plan and such Children:

   (1) Would satisfy the requirements of Subsection (C) or (D) above if they were the Children of the Retiree; and

   (2) Share the same legal residence as the Retiree.

A Covered Retiree’s or covered Domestic Partner’s Child is a Dependent only to the extent that each of the conditions under either Subsection (C), (D), or (E) of this Section is satisfied. Upon the failure of a Covered Retiree’s or a covered Domestic Partner’s Child to satisfy any of these conditions, the Child will cease to be a Dependent at the end of the month in which the loss of eligibility occurs.

A Covered Retiree’s or a covered Domestic Partner’s foster child with respect to whom a welfare agency assumes medical care costs is expressly excluded from the definition of Dependent under this Retiree Medical Plan.

If a Covered Retiree or a covered Domestic Partner claims a Child as a Dependent under this Section, the Plan Administrator may require the Covered Retiree to provide proof that each of the conditions under either Subsection (C), (D), or (E) of this Section is satisfied.
If a Covered Retiree claims a Child as a Dependent under Subsection (D) of this Section (or, similarly, if a covered Domestic Partner claims a Child as a Dependent under Subsection (E)), the Covered Retiree (or covered Domestic Partner) must provide proof that the Child is incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap. Such proof must be provided before coverage is continued under Subsection (D) or (E) of this Section. Additionally, such proof must be provided upon request at such time as the Plan Administrator may reasonably require. The Plan Administrator may require proof of continuing incapacity from time to time, but not more than once each year. A Child who is a Dependent under Subsection (D) or (E) of this Section is subject to all other provisions of this Retiree Medical Plan.

Further, notwithstanding any other provisions of this Retiree Medical Plan, no Dependent may be covered under this Retiree Medical Plan as a Covered Dependent of more than one Covered Retiree, and no Covered Person may be covered hereunder as both a Covered Retiree and a Covered Dependent.

Section 2.13 “Disabled Status” means any period of time during which an Employee (a) met the definition of an “eligible disabled person” under the Farm Credit Foundations Medical Plan and/or (b) was deemed to be disabled under, and/or entitled to and receiving benefits from, a group long term disability plan sponsored by any Farm Credit System entity.

Section 2.14 “Domestic Partner” means a person of the same or opposite sex for whom each of the following conditions is met:

(A) **Age Requirement.** The person is at least age eighteen (18);

(B) **Consent to Contract.** The person has attained the legal age to consent to contract according to the laws of the state in which the Retiree and the person reside;

(C) **No Blood Relationship.** The Retiree and the person are not related by blood in a degree that is closer than what would be permitted in the state in which they reside if the person and the Retiree desired to be married;

(D) **Cohabitation.** The Retiree and the person have lived together for at least six (6) consecutive months in an exclusive committed relationship of mutual caring and support and plan to continue their relationship indefinitely;

(E) **No Other Marriage or Domestic Partnership.** Neither the purported domestic person nor the Retiree is married to each other or to any other person, any prior marriages involving the person and/or the Retiree have been legally dissolved, the relationship between the person and the Retiree is exclusive, and there is no other person who is a spousal equivalent or Domestic Partner of either the person or the Retiree; and

(F) **Common Welfare and Financial Obligations.** The Retiree and the person are jointly responsible for each other’s common welfare and share financial obligations.
A covered Retiree’s domestic partner is a Domestic Partner only to the extent that each of the conditions listed in this Section is satisfied. Upon the failure of a covered Retiree’s Domestic Partner to satisfy any of these conditions, the Domestic Partner will cease to be a Domestic Partner on the last day of the month coincident with or next following the date on which the loss of eligibility occurs. If a person was not covered as a Domestic Partner under the Farm Credit Foundations Medical Plan, such person may not be a Domestic Partner under this Retiree Medical Plan. If a Covered Retiree claims a person as a Domestic Partner under this Section, the Plan Administrator may require the Covered Retiree to provide proof that each of the conditions listed above in this Section is satisfied. The Plan Administrator may require proof of continuing Domestic Partnership status from time to time, but not more than once each year.

Section 2.15 “Eligible Dependent” means a Dependent who satisfies the eligibility conditions of Article III.

Section 2.16 “Eligible Retiree” means a Retiree who satisfies the eligibility conditions of Article III.

Section 2.17 “Employee” means an individual employed by the Employer as a common law employee, excluding the following:

(A) Temporary Employees. A Temporary Employee is a person who is employed on a temporary or contract basis to meet unusual workloads or demands or to fill in while a regular Employee is on extended, sick or annual leave. Such individuals are not intended to be permanent employees. They are typically (although not always) scheduled to work less than nineteen (19) hours per week and/or less than 1,000 hours during a calendar year;

(B) Leased Employees. A Leased Employee is a person classified by the Employer on its payroll records as “leased employees” as that term is used in Code § 414(n);

(C) Part-Time Without Benefits Employees. A “Part-Time Without Benefits Employee” is an employee who is regularly scheduled to work less than twenty (20) hours per week; and

(D) Interns. An Intern is an employee who is assigned to a position in conjunction with a learning program. The length of the assignment is typically less than six (6) months.

Section 2.18 “Employer” means AgriBank, FCB; Former Ninth Farm Credit District Employers; Northwest Farm Credit Services; Western District Associations; and any other employer within the federal Farm Credit System who, with the permission of the Plan Sponsor Committee, has executed a Participation Agreement for this Retiree Medical Plan and the Participation Agreement remains in effect. Pursuant to the terms of the Administrative Agreement, the Plan Sponsor Committee is responsible for handling all settlor functions on behalf of the Employer under this Retiree Medical Plan.
Section 2.19 “Former Ninth Farm Credit District Employer” means an Employer listed in Schedule C of the Administrative Agreement; provided, however, such term shall not include any Western District Association.

Section 2.20 “Former Seventh Farm Credit District Employer” means an Employer listed in Schedule B of the Administrative Agreement.

Section 2.21 “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.22 “Insurance Contract” means the individual insurance contract entered into between the Insurer and the Retiree or his/her Dependent(s) who is/are participating in the Age 65 and Older Coverage pursuant to Article VII.

Section 2.23 “Insurer” means the insurance company chosen by the Plan Sponsor Committee to provide the Age 65 and Older Coverage pursuant to Article VII.

Section 2.24 “Medicare” means all parts of Health Insurance for the Aged provided by Title XVIII of the Federal Social Security Act, as amended from time to time.

Section 2.25 “Plan Administrator” means the Trust Committee. The Trust Committee may designate from time to time one or more individuals or other persons to carry out various administrative and other duties with respect to this Retiree Medical Plan in a manner consistent with the terms of this Retiree Medical Plan.

Section 2.26 “Plan Sponsor Committee” means the Farm Credit Foundations Plan Sponsor Committee, as established by the Administrative Agreement.

Section 2.27 “Plan Year” means the fiscal year of this Retiree Medical Plan, the twelve (12) consecutive month period beginning every January 1 and ending the subsequent December 31.

Section 2.28 “Qualifying Termination” means a termination of employment due to a participating Employer’s reorganization. Reorganization includes a merger, acquisition or change in control, which affects the Employee in one or more of the following ways:

(A) The Employee does not receive an offer of continued employment; and/or

(B) The Employee experiences an adverse change in status or position as a result of a material diminution in his/her duties, responsibilities, or authority with the Employer; and/or

(C) The Employee receives an offer of continued employment and such employment entails a decrease in salary; and/or

(D) The Employee receives an offer of continued employment but it requires relocation of at least 50 miles from the Employee’s current place of employment; and/or
(E) The Employer terminates (i) a written contract of employment between the Employer and the Employee or (ii) a written “change of control agreement” between the Employer and the Employee, which termination is not expressly authorized by such contract or agreement, or the Employer breaches such contract or agreement, other than an isolated, insubstantial, and inadvertent failure not occurring in bad faith and that is remedied by the Employer within a reasonable period after the Employer’s receipt of notice thereof from the Employee; and/or

(F) The Employer fails to comply with any material provision (i) of a written contract of employment between the Employer and the Employee or (ii) of a written “change of control agreement” between the Employer and the Employee, which failure has not been cured within the timeframe set forth in such contract or agreement.

Section 2.29 “Retiree” means a former Employee, even if that person has not “retired” and may include, for example, a disabled person over the age of 65 who is receiving benefits under the Group Long Term Disability Plan contained within the Farm Credit Foundations Employer Provided Welfare Benefits Plan. For avoidance of confusion, a Retiree does not become eligible for coverage under this Retiree Medical Plan (i.e., does not become an Eligible Retiree) unless and until the Retiree satisfies the eligibility conditions set forth in Article III. This definition of Retiree is intended to be used solely for the purpose of administering this Retiree Medical Plan.

Section 2.30 “Retiree Medical Plan” means the Farm Credit Foundations Retiree Medical Plan. The Retiree Medical Plan consists of this Wrap Around Plan Document, the Benefit Description, and the Benefit Schedules which are incorporated by reference and made a part of the Benefit Description.

Section 2.31 “Retirement Date” means the date an Employee’s coverage ceased under the Farm Credit Foundations Medical Plan; provided, however, for purposes of Part B of Article III, “Retirement Date” means the date the Employee’s coverage ceased under the Ninth Farm Credit District Employee Group Medical Plan or the Farm Credit Consolidated Medical Plan. In determining the date when an Employee’s coverage ceased under the Farm Credit Foundations Medical Plan, continuation coverage under such plan shall not be considered, except to the extent that such plan permits coverage under this Retiree Medical Plan to commence following continuation coverage under the Farm Credit Foundations Medical Plan.

Section 2.32 “Spouse” means a person of the same or opposite sex to whom the participant is legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which the couple currently resides. An individual will not be considered a Spouse for purposes of this Retiree Medical Plan if (i) his/her marriage to the participant has been terminated by a court having jurisdiction over one or both parties to the marriage or (ii) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.
A common law marriage to a person of the opposite sex shall be considered to be a legal marriage if the common law marriage was entered into in a state that recognizes common law marriage and if the common law marriage is recognized as valid under the laws of that state. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of legal marriage (including, as may be applicable, the existence of a common law marriage).

**Section 2.33** “Trust Committee” means the Farm Credit Foundations Trust Committee, as established by the Administrative Agreement.

**Section 2.34** “Under Age 65 Coverage” means the coverage provided through Article VI of this Retiree Medical Plan.

**Section 2.35** “Western District Association” means an Employer listed among the Former Eleventh District Associations in Schedule C of the Administrative Agreement.

**Section 2.36** “Wrap Around Plan Document” means this Retiree Medical Plan document, consisting of the Preamble through Article XV of this Retiree Medical Plan, but not including the Benefit Description or Benefit Schedules attached hereto, which this Wrap Around Plan Document incorporates by reference.
ARTICLE III
ELIGIBILITY AND PARTICIPATION

Section 3.01 General Requirements for Coverage. To become a Covered Person under this Retiree Medical Plan, an individual must satisfy each of the following requirements:

(A) The individual must be either a Retiree or a Dependent; and

(B) The individual must satisfy the eligibility conditions set forth in this Article III for becoming an Eligible Retiree or Eligible Dependent; and

(C) The individual must be enrolled in this Retiree Medical Plan in accordance with Article IV; and

(D) The individual must not have waived coverage pursuant to Section 4.06 and

(E) The individual must not have elected continuation coverage under the Farm Credit Foundations Medical Plan, unless the Farm Credit Foundations Medical Plan expressly permitted coverage under this Retiree Medical Plan to commence following continuation coverage under the Farm Credit Foundations Medical Plan.

PART A – ELIGIBILITY REQUIREMENTS FOR POST-2006 RETIREES

Section 3.02 Requirements for a Retiree to Become an Eligible Retiree. A Retiree whose Retirement Date is on or after January 1, 2007, is eligible to participate in this Retiree Medical Plan if he/she has satisfied the conditions set forth in either Subsection (A), Subsection (B), Subsection (C), Subsection (D), and/or Subsection (E):

(A) The Retiree, as of his/her Retirement Date, meets each of the following conditions:

(1) The Retiree is age 55 or older; and

(2) The Retiree has at least ten (10) years of continuous service – whether on active or Disabled Status – with the Employer or any other federal Farm Credit System entity, provided that:

(a) The service with the other federal Farm Credit System entity(ies) immediately preceded service with the Employer; and

(b) The amount of service accrued during any period of Disabled Status is no greater than the amount of service accrued as an active Employee; and
(3) The Retiree was covered under the Farm Credit Foundations Medical Plan on the day immediately prior to his/her Retirement Date.

(B) The Retiree, as of his/her Retirement Date, meets each of the following conditions:

(1) The Retiree is age 50 or older; and

(2) The Retiree has at least ten (10) years of continuous service – whether on active or Disabled Status – with the Employer or any other federal Farm Credit System entity, provided that:

(a) The service with the other federal Farm Credit System entity(ies) immediately preceded service with the Employer; and

(b) The amount of service accrued during any period of Disabled Status is no greater than the amount of service accrued as an active Employee; and

(3) The Retiree is receiving enhanced pension benefits under a defined benefit plan maintained by the Employer pursuant to a special early retirement program, which adds five (5) years to the actual age of the Retiree and five (5) years to the Retiree’s actual years of service for purposes of computing the Retiree’s benefit under such plan; and

(4) The Retiree either experiences a Qualifying Termination or is entitled to receive enhanced pension benefits under the terms and conditions of the defined benefit plan in which the Retiree is participating pursuant to Subsection (3) above.

(C) The Retiree, as of his/her Retirement Date, meets each of the following conditions:

(1) The Retiree’s Employer is AgStar Financial Services, ACA (“AgStar”); and

(2) The Retiree is age 50 or older; and

(3) The Retiree has ten (10) or more years of service with AgStar or any other Farm Credit System entity, provided that the service with the other federal Farm Credit System entity(ies) immediately preceded service with AgStar; and

(4) The Retiree is participating in the AgriBank District Retirement Plan; and

(5) The Retiree is receiving benefits under the AgStar Financial Services, ACA Supplemental Executive Retirement Plan, as a result of having entered into an Executive Employment Agreement and Change of Control Agreement with AgStar in 2006.
(D) The Retiree, as of his/her Retirement Date, meets each of the following conditions:

1. The Retiree’s Employer is a Former Ninth Farm Credit District Employer or a Western District Association; and

2. The Retiree either (a) is age 55 or older and has ten (10) or more years of service with a Farm Credit System employer, or (b) satisfies the “rule of 85” by having the sum of his/her age and years of service be equal to or greater than eighty-five (85); and

3. The Retiree is not a participant in the Ninth Farm Credit District Pension Plan, but instead is accruing benefits under The Eleventh Farm Credit District Employees’ Retirement Plan; and

4. The Retiree was covered under the Farm Credit Foundations Medical Plan on the day immediately prior to his/her Retirement Date.

(E) The Retiree, as of his/her Retirement Date, meets each of the following conditions:

1. The Retiree is age 65 or older; and

2. The Retiree is:

   a. Deemed disabled pursuant to the Group Long Term Disability Plan contained within the Farm Credit Foundations Employer Provided Welfare Benefits Plan; and/or

   b. Entitled to and is receiving benefits under the Farm Credit Foundations Group Long Term Disability Plan.

(F) The Retiree meets each of the following conditions:

1. As of the Retiree’s Retirement Date, he/she satisfied the definition of a “disabled person” under the Farm Credit Foundations Medical Plan (i.e., was deemed disabled pursuant to, or receiving benefits under, the Group Long Term Disability Plan within the Farm Credit Foundations Employer Provided Welfare Benefits Plan); and

2. The Retiree discontinued his/her coverage under the Farm Credit Foundations Medical Plan in order to receive medical coverage pursuant to Medicare;

3. At the time the Retiree seeks to enroll in this Retiree Medical Plan, he/she would have satisfied the requirements to become an Eligible Retiree (pursuant to one of Subsections (A) through (E) of this Section) had he/she remained continuously covered under the Farm Credit Foundations Medical Plan; and
(4) At the time the Retiree seeks to enroll in this Retiree Medical Plan, he/she would be eligible to receive an employer subsidy under the Retiree Medical Plan.

PART B – ELIGIBILITY REQUIREMENTS FOR PRE-2007 RETIREES

Section 3.03 Retirees from Participating Employers in the Former Ninth Farm Credit District Retiree Group Medical Benefits Plan. A Retiree whose Retirement Date was prior to January 1, 2007, is eligible to participate in this Retiree Medical Plan if he/she has satisfied the conditions set forth in Subsection (A), Subsection (B), or Subsection (C):

(A) Retired Employee Receiving Pension Benefits. A former employee of an Employer, which had adopted the Ninth Farm Credit District Retiree Group Medical Benefits Plan, who:

(1) Was age 55 or older on his/her Retirement Date; and

(2) Had ten (10) or more years of service with a Farm Credit System employer and had accumulated at least five (5) years of service with a Former Ninth Farm Credit District Employer following his/her last inter-district transfer; and

(3) Retired and began to receive benefits under the Ninth Farm Credit District Pension Plan on the first day of the month following his/her Retirement Date; and

(4) Was covered under the Ninth Farm Credit District Employee Group Medical Plan on his/her Retirement Date; and

(5) Elected to participate in the Ninth Farm Credit District Retiree Group Medical Benefits Plan prior to his/her Retirement Date.

(B) Retired Employee Receiving “Enhanced” Pension Benefits. A former employee of an Employer, which had adopted the Ninth Farm Credit District Retiree Group Medical Benefits Plan, who:

(1) Was age 50 or older on his/her Retirement Date; and

(2) Had fifteen (15) or more years of service with a Farm Credit System employer and had accumulated at least five (5) years of service with a Former Ninth Farm Credit District Employer following his/her last inter-district transfer; and

(3) Retired and began to receive benefits under the Enhanced Benefits provisions of the Ninth Farm Credit District Pension Plan, as outlined in Section 6.07 of such plan, on the first day of the month following his/her Retirement Date; and
(4) Was covered under the Ninth Farm Credit District Employee Group Medical Plan on his/her Retirement Date; and

(5) Elected to participate in the Ninth Farm Credit District Retiree Group Medical Benefits Plan prior to his/her Retirement Date.

(C) **Retired Employee of an Affiliated Employer.** A former employee of an Employer, which had affiliated with the former Ninth Farm Credit District and adopted the Ninth Farm Credit District Retiree Group Medical Benefits Plan, who:

(1) Had coverage terminated under the retiree medical plan of the former Farm Credit District of the Employer as a result of the Employer's affiliation with the former Ninth Farm Credit District; or

(2) Would have been eligible to participate in the retiree medical plan of the former Farm Credit District of the Employer on his/her Retirement Date had the Employer continued to remain affiliated with the former Farm Credit District.

Section 3.04 **Retirees from Participating Employers in the Farm Credit Retiree Medical Plan.** A Retiree whose Retirement Date was prior to January 1, 2007, is eligible to participate in this Retiree Medical Plan if he/she has satisfied the conditions set forth in Subsection (A), Subsection (B), Subsection (C), or Subsection (D):

(A) **Seventh Farm Credit District.** A former employee of a Former Seventh Farm Credit District Employer who:

(1) Was age 55 or older on his/her Retirement Date from the Former Seventh Farm Credit District Employer; and

(2) Had ten (10) or more years of service with a Farm Credit System Employer as of his/her Retirement Date; and

(3) Was covered under the Farm Credit Consolidated Medical Plan on his/her Retirement Date; and

(4) Elected to participate in the Farm Credit Retiree Medical Plan as of his/her Retirement Date.

(B) **Farm Credit Services of America.** A former employee of Farm Credit Services of America who satisfies the requirements of Subsection (B)(1), Subsection (B)(2), or Subsection (B)(3) below:

(1) Was hired prior to January 1, 2002 and:

(a) Was age 55 or older on his/her Retirement Date from Farm Credit Services of America; and

(b) Had ten (10) or more years of service with Farm Credit Services of America as of his/her Retirement Date; and
(c) Was covered under the Farm Credit Consolidated Medical Plan on his/her Retirement Date; and

(d) Elected to participate in the Farm Credit Retiree Medical Plan as of his/her Retirement Date.

(2) Was hired prior to January 1, 2002 and:

(a) Was age 40 or older on December 31, 2001; and

(b) Was age 55 or older on his/her Retirement Date from Farm Credit Services of America; and

(c) Had five (5) or more years of service with Farm Credit Services of America as of his/her Retirement Date; and

(d) Was covered under the Farm Credit Consolidated Medical Plan on his/her Retirement Date; and

(e) Elected to participate in the Farm Credit Retiree Medical Plan as of his/her Retirement Date.

(3) Was hired on or after January 1, 2002 and before January 1, 2007, and:

(a) Was age 55 or older on his/her Retirement Date from Farm Credit Services of America; and

(b) Had ten (10) or more years of service with Farm Credit Services of America as of his/her Retirement Date; and

(c) Was covered under the Farm Credit Consolidated Medical Plan on his/her Retirement Date; and

(d) Elected to participate in the Farm Credit Retiree Medical Plan as of his/her Retirement Date.

(C) **Northwest Farm Credit Services.** A former employee of Northwest Farm Credit Services who:

(1) Was hired prior to January 1, 2007; and

(2) Was age 55 or older on his/her Retirement Date from Northwest Farm Credit Services; and

(3) Had ten (10) or more years of service with Northwest Farm Credit Services as of his/her Retirement Date; and

(4) Was covered under the Farm Credit Consolidated Medical Plan on his/her Retirement Date; and
(5) Elected to participate in the Farm Credit Retiree Medical Plan as of his/her Retirement Date.

(D) **Western District Association.** A former employee of a Western District Association who satisfied: (i) either Subsection (D)(1) or Subsection (D)(2); and (ii) Subsection (D)(3); and (iii) Subsection (D)(4).

(1) Was hired prior to January 1, 2002 and satisfied one of the following subparagraphs:

(a) Met the “rule of 85” as of his/her Retirement Date, such that the sum of his/her age and years of service with a Farm Credit System employer is equal to or greater than eighty-five (85); or

(b) Was age 65 or older as of his/her Retirement Date from the Western District Association; or

(c) Was between the age of 62 and 64, with at least five and one-half (5½) years of service with the Western District Association, as of his/her Retirement Date; or

(d) Was age 60 or 61, with at least fifteen (15) years of service with the Western District Association, as of his/her Retirement Date; or

(e) Was age 55, with at least ten (10) years of service with the Western District Association, as of his/her Retirement Date.

(2) Was hired between January 1, 2002 and December 31, 2006, and:

(a) Was age 55 or older as of his/her Retirement Date from the Western District Association; and

(b) Had ten (10) or more years of service with the Western District Association as of his/her Retirement Date.

(3) Was covered under the Farm Credit Consolidated Medical Plan as of his/her Retirement Date; and

(4) Elected to participate in the Farm Credit Retiree Medical Plan prior to his/her Retirement Date.
PART C – ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

Section 3.05 Requirements for a Dependent to Become an Eligible Dependent. A Dependent of a Retiree is eligible to be enrolled in this Retiree Medical Plan (i.e., becomes an Eligible Dependent) if the conditions in Subsections (A), (B), and (C) are each met:

(A) Either of the following elements are satisfied:

   (1) The Eligible Retiree through whom the Dependent will receive coverage is enrolled (i.e., is a Covered Retiree) in this Retiree Medical Plan; or

   (2) The Retiree through whom the Dependent would have received coverage under this Retiree Medical Plan has died and each of the following is true:

      (a) As of the Retiree’s Retirement Date, he/she was participating as a “disabled person” under the Farm Credit Foundations Medical Plan;

      (b) The Retiree discontinued his/her coverage under the Farm Credit Foundations Medical Plan in order to receive medical coverage pursuant to Medicare;

      (c) At the time of the Retiree’s death, the Retiree would have satisfied the requirements to become an Eligible Retiree under this Retiree Medical Plan had he/she remained continuously covered under the Farm Credit Foundations Medical Plan;

      (d) At the time of the Retiree’s death, the Retiree would have been eligible to receive an employer subsidy under this Retiree Medical Plan; and

      (e) At the time the Dependent seeks to enroll in this Retiree Medical Plan, he/she would be eligible to receive an employer subsidy under this Retiree Medical Plan.

(B) The Dependent is not ineligible for coverage under this Retiree Medical Plan pursuant to the provisions of Sections 3.06; and

(C) If the Dependent met the definition of a “dependent” under the Farm Credit Foundations Medical Plan on the Eligible Retiree’s Retirement Date, the Dependent was covered as a dependent under such plan on that date.
Section 3.06 Restrictions on Dependents’ Coverage Under this Plan. The following rules apply to all Dependents of an Eligible Retiree:

(A) **May Not be a Covered Dependent of More Than One Retiree.** No Dependent may be covered under this Retiree Medical Plan as a Covered Dependent of more than one Covered Retiree.

(B) **May Not be Covered Under the Farm Credit Foundations Medical Plan.** No Dependent may be covered under this Retiree Medical Plan as a Covered Dependent of a Covered Retiree while, at the same time, being covered under the Farm Credit Foundations Medical Plan as either an “employee” (as that term is defined in the Farm Credit Foundations Medical Plan) or as a covered “dependent” of an “employee” (as those terms are defined in the Farm Credit Foundations Medical Plan).

For example, if the Spouse of an Eligible Retiree is also an Employee covered under the Farm Credit Foundations Medical Plan, the Eligible Retiree and his/her Spouse must choose one of the following options:

(1) The Eligible Retiree may enroll in this Retiree Medical Plan and his/her Spouse (along with any other Eligible Dependents) may be covered as a Covered Dependent under this Retiree Medical Plan; or

(2) The Eligible Retiree may enroll in this Retiree Medical Plan and the Employee-Spouse may continue to be covered under the Farm Credit Foundations Medical Plan. Dependents who are eligible for coverage may be covered with either (a) the Eligible Retiree under this Retiree Medical Plan, or (b) the Employee-Spouse under the Farm Credit Foundations Medical Plan, assuming that the conditions for coverage under the applicable plan are otherwise satisfied.

(C) **May Not be Both a Covered Retiree and a Covered Dependent.** No person may be covered under this Retiree Medical Plan as both a Covered Retiree and a Covered Dependent.

For example, if the Spouse or Domestic Partner of an Eligible Retiree is also an Eligible Retiree, the Eligible Retiree and his/her Spouse/Domestic Partner must choose one of the following options:

(1) Each Spouse/Domestic Partner may enroll separately with the result that each Spouse/Domestic Partner will be a Covered Retiree; or

(2) Either Spouse/Domestic Partner may enroll as the Covered Retiree and the other Spouse/Domestic Partner, along with any other eligible Dependents, may be covered as a Covered Dependent.
(D) **May Not be a Member of the Armed Forces of Any Country.** No Dependent may be covered under this Retiree Medical Plan as a Covered Dependent if such Dependent is a member of the armed forces of any country.

**Section 3.07 Special Proof Rules Applicable to Dependent Children.** The following rules apply to Dependent Children of an Eligible Retiree:

(A) **Proof of Dependent Status.** If a Covered Retiree claims a Child as a Dependent, the Plan Administrator may require the Covered Retiree to provide whatever documentation is necessary to prove that the Child meets the conditions of being a Dependent.

(B) **Proof that Child is Incapable of Employment or is Totally Disabled.** If a Covered Retiree claims a Child as a Dependent because the Child is incapable of employment or is totally disabled, the Covered Retiree must provide proof that the Child is incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap, or that the Child is totally disabled. Such proof must be provided before coverage is continued. Additionally, such proof must be provided periodically thereafter so long as coverage under the Retiree Medical Plan continues. The Plan Administrator may require proof of continuing incapacity from time to time, but not more than once each year. Failure to submit required proof or to allow medical or psychiatric examination of the Child will be considered affirmative proof that the Child is no longer incapacitated or Totally Disabled.

**PART D – OTHER ELIGIBILITY RULES**

**Section 3.08 Rehired Retirees.** A Covered Retiree who becomes reemployed by the Employer will continue to be an Eligible Retiree and may continue to be covered under this Retiree Medical Plan if:

(A) Prior to becoming reemployed by the Employer, the former Employee was an Eligible Retiree under Section 3.01; and

(B) The Employee is not eligible to participate in the Farm Credit Foundations Medical Plan.

**Section 3.09 Retirees of Affiliating Employers.** In the case of any Retiree of a Farm Credit System entity that becomes an Employer under this Retiree Medical Plan in accordance with Section 2.18 on or after January 1, 2007, the determination of whether such Retiree should be eligible for coverage under this Retiree Medical Plan shall be made in accordance with the provisions of the affiliation agreement entered into between AgriBank, the Former Ninth Farm Credit District Employer, or the Western District Association, and such other Farm Credit System Employer, provided such provisions have been approved by the Plan Sponsor Committee. If such a Retiree is determined to be eligible for coverage under this Retiree Medical Plan, the Retiree shall become a Covered Retiree in this Retiree Medical Plan as of the date set forth in the affiliation agreement.
ARTICLE IV
TIME & DURATION OF COVERAGE

Section 4.01 General Rule Regarding Time and Duration of Coverage. If a Retiree or Dependent satisfies the eligibility requirements for coverage set forth in Article III, his/her coverage under this Retiree Medical Plan will commence, and continue to remain in effect, in accordance with the provisions of this Article IV.

PART A – RETIREE COVERAGE

Section 4.02 Commencement of Coverage for Pre-2007 Retirees. A Retiree whose Retirement Date was prior to January 1, 2007, and who satisfied the eligibility requirements for coverage set forth in Part B of Article III, shall be covered under this Retiree Medical Plan without any further necessary action, effective January 1, 2007. Such Retiree’s enrollment in his/her prior retiree medical plan shall constitute a valid enrollment for this Retiree Medical Plan.

Section 4.03 Enrollment by Post-2006 Retirees. A Retiree whose Retirement Date is on or after January 1, 2007, and who satisfies the eligibility requirements for coverage set forth in Parts A or D of Article III, shall be covered under this Retiree Medical Plan, effective on the date specified in Section 4.04, if he/she makes a timely election for coverage by completing and returning the proper enrollment forms to the Plan Administrator no later than sixty (60) days following his/her Retirement Date.

Section 4.04 Commencement of Coverage for Post-2006 Retirees. A Retiree who satisfies the conditions set forth in Section 4.03 shall be covered under this Retiree Medical Plan on the first day or the sixteenth day of the month coincident with or next following his/her Retirement Date.

Section 4.05 Duration of Retiree Coverage. A Retiree’s coverage as a Covered Retiree under the Retiree Medical Plan shall terminate on the earliest of:

(A) The date this Retiree Medical Plan terminates; or

(B) The end of the period for which a required Retiree contribution was last paid on or before the date on which it was due; or

(C) The date on which the Retiree becomes covered as a Covered Dependent under this Retiree Medical Plan or as an Employee’s Covered Dependent under the Farm Credit Foundations Medical Plan; or

(D) The date on which the Employer’s participation in the Administrative Agreement is terminated; or

(E) The Retiree’s death; or

(F) The date the Retiree affirmatively elects to discontinue coverage under the Retiree Medical Plan; or
(G) In the case of an individual who was solely eligible for this Retiree Medical Plan by virtue of Section 3.02(E), the date that he/she exhausts the Maximum Period Payable, as defined in the Group Long Term Disability Plan contained within the Farm Credit Foundations Employer Provided Welfare Benefits Plan; provided, however, that such individual’s coverage under this Retiree Medical Plan shall not terminate if he/she has a total of ten years or more of continuous service – whether on active or Disabled Status – with the Employer or any other federal Farm Credit System entity as of the date that the individual exhausts the Maximum Period Payable.

Section 4.06 Waiver of Coverage. If an Eligible Retiree fails to make a timely election for coverage under this Retiree Medical Plan within sixty (60) days of his/her Retirement Date, the eligibility and option to attain coverage hereunder will be irretrievably lost, and coverage will never again be available. Additionally, eligibility for coverage under this Retiree Medical Plan will be permanently and irretrievably lost if, after having been covered under this Retiree Medical Plan, a Covered Retiree allows his/her coverage to lapse.

PART B – DEPENDENT COVERAGE

Section 4.07 General Enrollment Period for Eligible Dependents. Except as otherwise provided in this Part B of Article IV, an Eligible Dependent of a Covered Retiree may participate in this Retiree Medical Plan only if a timely election for coverage is made on his/her behalf by completing and returning the proper enrollment forms to the Plan Administrator by the later of:

(A) The date the Covered Retiree makes a timely election for his/her own coverage pursuant to Section 4.03; or

(B) Thirty-one (31) days after the date on which the Eligible Dependent first comes within (or again comes within) the definition of an Eligible Dependent, or such longer period of time as may be permitted by Part B of this Article IV.

Section 4.08 Special Enrollment Period for Dependents Previously Covered Under Health Insurance Plans. The occurrence of either of the following two events described in Subsections (A) and (B) below shall result in a Special Enrollment Period of limited duration for the Dependent (other than a Domestic Partner) of a Retiree who is not already enrolled and covered under this Retiree Medical Plan:

(A) Loss of Other Health Coverage. A Covered Retiree’s Dependent (other than a Domestic Partner) for whom coverage was not elected under this Retiree Medical Plan because such Dependent was covered under another group health plan or had other health insurance coverage may still enroll in this Retiree Medical Plan if such alternative coverage terminated because of an event specified in either Subsection (1) or (2) below:
(1) There was a loss of eligibility for such alternative coverage. A loss of eligibility includes the following:

(a) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status, death, reduction in the number of hours of employment, or exhaustion of the maximum COBRA period; or

(b) Loss of eligibility due to the incurrence of a claim causing the individual to meet or exceed a lifetime limit on all benefits; or

(c) Loss of eligibility for coverage through an HMO in the individual market because the individual no longer resides, lives, or works in a service area; or

(d) Loss of eligibility for Medicaid coverage or coverage under a state’s children’s health insurance program ("SCHIP"), on or after April 1, 2009.

Note: A loss of eligibility does not include a loss resulting from the failure of the Dependent to pay premiums on a timely basis or a termination of coverage for cause (e.g., fraud).

or

(2) Employer contributions toward such other coverage ceased;

The special enrollment period expires 31 days after the alternative coverage terminates, except that the Special Enrollment Period expires 60 days after the coverage described in Section 4.08(A)(1)(d) above terminates. Coverage elected during this special enrollment period will commence on the later of the date that the alternative coverage terminates or the date on which the Retiree or Dependent timely submits his/her proper enrollment forms to the Plan Administrator.

(B) Eligibility for a State Premium Assistance Subsidy Under the Medical Plan from Medicaid or SCHIP. A Dependent may enroll in this Retiree Medical Plan if, on or after April 1, 2009, he/she becomes eligible for a state premium assistance subsidy under this Retiree Medical Plan from Medicaid or a SCHIP.

The Special Enrollment Period expires 60 days after becoming eligible for the state premium assistance subsidy. Coverage elected during this Special Enrollment Period will commence on the later of the date the Dependent becomes eligible for the state premium assistance subsidy or the date on which the Retiree or Dependent timely submits his/her proper enrollment forms to the Plan Administrator.
Section 4.09 Commencement of Eligible Dependents’ Coverage. Except as expressly provided otherwise in this Article IV, the effective date of an Eligible Dependent’s coverage under this Retiree Medical Plan shall be governed by the following rules:

(A) **General Rule.** If a Covered Retiree has one or more Eligible Dependents on the date he/she commences coverage under this Retiree Medical Plan, and he/she elects the “Family Coverage” option (or the “Retiree Plus Spouse Coverage” option or the “Retiree Plus Child(ren) Coverage” option), the enrolled Eligible Dependents’ coverage under this Retiree Medical Plan shall become effective on the date on which coverage is effective for such Covered Retiree; and

(B) **Exception for Special Enrollment Period.** If a Covered Retiree enrolls his/her Eligible Dependent in this Retiree Medical Plan pursuant to the Special Enrollment Period provisions set forth in Section 4.08, the enrolled Eligible Dependent’s coverage under this Retiree Medical Plan shall become effective on the date of the relevant event that triggered the Special Enrollment Period pursuant to Section 4.08(A).

Section 4.10 Newly-Elected Coverage for Newly-Acquired (or Newly-Eligible) Non-Newborn Dependents. If a Covered Retiree acquires an Eligible Dependent (other than a newborn infant described in Section 4.11 below or a Domestic Partner) after the Covered Retiree’s effective date of coverage, or if the Covered Retiree’s Spouse or Child comes into conformity with the definition of an Eligible Dependent after the Covered Retiree’s effective date of coverage, and the Retiree thereupon or thereafter elects the “Family Coverage” option (or the “Retiree Plus Spouse Coverage” option or the “Retiree Plus Child(ren) Coverage” option), the enrolled Eligible Dependent’s coverage under this Retiree Medical Plan shall become effective on the date the Covered Retiree acquired the Eligible Dependent, provided that the enrollment/status change form has been received by the Plan Administrator prior to such date. If the requisite form is received by the Plan Administrator after such date, then coverage shall become effective on the first day of the month next following the date that the form is received by the Plan Administrator. In all events, however, the enrollment/status change form must be received by the Plan Administrator no later than thirty-one (31) days after the date such Dependent qualifies as an Eligible Dependent under this Retiree Medical Plan. If the enrollment/status change form is not received within thirty-one (31) days after the date such Dependent qualifies as an Eligible Dependent, such Dependent will be precluded from receiving coverage under this Retiree Medical Plan.

Section 4.11 Newly-Elected Coverage for Newborn Dependents Acquired by Birth or Adoption. If a Covered Retiree acquires a newborn Eligible Dependent, by way of birth or adoption, after the Covered Retiree’s effective date of coverage, and thereupon or thereafter elects the “Family Coverage” option (or the “Retiree Plus Spouse Coverage” option or the “Retiree Plus Child(ren) Coverage” option), such Eligible Dependent’s coverage under this Retiree Medical Plan shall become effective as of the date of such Eligible Dependent’s birth or adoption, as applicable, provided that the enrollment/status change form and payment of the premium rate for dependent coverage are received by the Plan Administrator no later than sixty (60) days after the date of the Eligible Dependent’s birth or adoption, as applicable. If, after sixty (60) days, the Covered Retiree has not elected a coverage option sufficient to include the new Eligible Dependent, enrolled such Eligible Dependent, and paid the appropriate premium, the Eligible Dependent will be precluded from receiving coverage under this Retiree Medical Plan.
Section 4.12 Extension of Existing Family Coverage. If a Covered Retiree, who currently has the “Family Coverage” option (or the “Retiree Plus Spouse Coverage” or “Retiree Plus Child(ren) Coverage” options), extends his/her coverage to include an additional Eligible Dependent (whether newly-acquired (other than a Domestic Partner or newly-eligible), the effective date of such Eligible Dependent’s coverage will be governed by the following rules:

(A) Newly-Acquired Newborn Dependents by Birth or Adoption. If the Covered Retiree has the “Family Coverage” option (or the “Retiree Plus Spouse Coverage” option or the “Retiree Plus Child(ren) Coverage” option) and thereafter acquires a newborn Eligible Dependent by way of birth or adoption, such Eligible Dependent’s coverage under this Retiree Medical Plan shall become effective as of the date of such Eligible Dependent’s birth or adoption, as applicable, provided that the enrollment/status change form is received by the Plan Administrator no later than sixty (60) days after the date of the Eligible Dependent’s birth or adoption, as applicable. If the requisite enrollment/status change form has not been received by the Plan Administrator within sixty (60) days of the Eligible Dependent’s birth or adoption, as applicable, the Eligible Dependent will be precluded from receiving coverage under this Retiree Medical Plan.

(B) Dependents Newly-Eligible for Reasons Other than Birth or Adoption. If the Covered Retiree has the “Family Coverage” option (or the “Retiree Plus Spouse Coverage” option or the “Retiree Plus Child(ren) Coverage” option) and, thereafter, the Covered Retiree’s Spouse or Child first comes (or again comes) into conformity with the definition of an Eligible Dependent for reasons other than birth or adoption, the Spouse or Child’s coverage under this Retiree Medical Plan becomes effective on the date such individual first came (or again came) into conformity with the definition of an Eligible Dependent, provided that the enrollment/status change form is received by the Plan Administrator no later than thirty-one (31) days after such date. If the requisite enrollment/status change form has not been received by the Plan Administrator within thirty-one (31) days of such date, the Eligible Dependent will be precluded from receiving coverage under this Retiree Medical Plan.

Section 4.13 Duration of Dependent Coverage – General Rule. Except as expressly provided otherwise in Sections 4.14 and 4.16 below, a Covered Dependent’s coverage under the Retiree Medical Plan shall terminate on the earliest of:

(A) The date this Retiree Medical Plan terminates; or

(B) The date of termination of coverage of the Covered Retiree through whom the Covered Dependent is receiving coverage; or

(C) The last day of the month coincident with or next following the date the Covered Dependent no longer meets the Retiree Medical Plan’s definition of a Dependent, or no longer satisfies the Retiree Medical Plan’s eligibility requirements; or
(D) The end of the month in which the Covered Dependent enters active service in the armed forces of any country, except temporary active service of two (2) weeks or less; or

(E) The end of the period for which a Covered Retiree’s required contribution was last paid on or before the date on which it was due; or

(F) The date upon which the Covered Dependent becomes covered as a Covered Retiree under this Retiree Medical Plan or as a covered employee under the Farm Credit Foundations Medical Plan.

Section 4.14 Covered Dependent Spouse’s Coverage Following Death of Covered Retiree. In the event of the death of a Covered Retiree, a Covered Dependent Spouse or covered Domestic Partner – regardless of his/her age – may maintain his/her coverage under the Retiree Medical Plan by paying the applicable premium. In this circumstance, the coverage of the Covered Dependent Spouse or the covered Domestic Partner would not be subject to the continuation of coverage provisions set forth in Part C of this Article IV. Instead, the Covered Dependent Spouse or covered Domestic Partner shall assume the same rights and obligations under this Retiree Medical Plan to which the Covered Retiree would be subject had he/she not pre-deceased the Covered Dependent-Spouse or covered Domestic Partner; provided, however, a surviving Covered Dependent-Spouse or covered Domestic Partner may not obtain coverage under this Retiree Medical Plan for a newly-acquired Dependent Spouse or Domestic Partner.

PART C – CONTINUATION OF COVERAGE

Section 4.15 Continuation of Coverage – Age 65 and Older Coverage. No continuation coverage shall be provided to Covered Persons as part of the Age 65 and Older Coverage of this Retiree Medical Plan.

Section 4.16 Continuation of Coverage – Under Age 65 Coverage. If a “qualified beneficiary” loses (or would lose) coverage under the Under Age 65 Coverage of this Retiree Medical Plan as a result of a “qualifying event,” the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by making an election to that effect, in accordance with such procedures as the Plan Administrator may from time to time establish, and by paying the applicable premium. The qualified beneficiary’s right to continue coverage under this Retiree Medical Plan is subject to the following rules:

(A) Qualified Beneficiary. For purposes of this Section, a “qualified beneficiary” means any Covered Person who was covered under the Under Age 65 Coverage of this Retiree Medical Plan, as set forth in Article VI, on the day before the “qualifying event,” but only if such person is not eligible for enrollment in Medicare Part A or Part B based on his/her attainment of age 65 at the time of the “qualifying event.” The term “qualified beneficiary” shall also include any Dependent Children who are born to or acquired by a Covered Retiree or Covered Dependent Spouse or Domestic Partner while he/she is continuing his/her coverage.
(B) **Qualifying Event.** For purposes of this Section, a “qualifying event” means one of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Retiree Medical Plan as a result of such an event:

(1) Death of the Covered Retiree;

(2) Divorce or legal separation of the Covered Retiree and the Covered Retiree’s Covered Dependent Spouse; or

(3) A Covered Dependent no longer satisfies the conditions for being covered as a Dependent of the Covered Retiree.

(C) **Election to Continue Coverage.** Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the Plan Administrator and must be made in accordance with such reasonable procedures as the Plan Administrator may establish.

(D) **Premium for Continuation Coverage.** A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the Plan Administrator may establish.

(E) **Maximum Coverage Period – General Rule.** Except as provided otherwise in Subsection (F) below, the maximum period of time for which continuation coverage will be provided shall be thirty-six (36) months.

(F) **Maximum Coverage Period for Non-Spouse Surviving Dependents.** A Covered Dependent (other than the Covered Retiree’s Spouse or Domestic Partner) who elects continuation coverage following the Covered Retiree’s death may continue such coverage under this Retiree Medical Plan until the earliest of the following:

(1) The death of the Covered Dependent; or

(2) The end of the month in which the Covered Dependent ceases to meet the definition of Dependent; or

(3) The date the Covered Dependent becomes eligible for and enrolled in benefits under another group health plan; or

(4) The end of a period for which a required contribution was last paid.
(G) **Termination of Qualified Beneficiary’s Continuation Coverage.** A qualified beneficiary’s continuation coverage may be terminated prior to the expiration of the maximum coverage period upon the occurrence of any of the following events:

1. The Employer terminates this Retiree Medical Plan and no longer offers coverage under a group health plan to any of its Retirees; or
2. The qualified beneficiary becomes covered under another group health plan; or
3. The qualified beneficiary becomes eligible to enroll in Medicare based on his/her attainment of age 65 (regardless of whether the qualified beneficiary is actually enrolled in Medicare); or
4. A required premium is not paid within the applicable deadline (including any applicable grace period).

(H) **Coverage Provided During Continuation Period.** The coverage provided during the continuation period shall be identical to the coverage provided to similarly situated persons covered under the Retiree Medical Plan with respect to whom a qualifying event has not occurred. If coverage under the Retiree Medical Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage.

(I) **Calculation of Continuation Coverage Deadlines.** The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Retiree Medical Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.
ARTICLE V
COVERAGE OPTIONS

Section 5.01 General Rule. The coverage that is available under this Retiree Medical Plan is dependent on the age of the Covered Person.

(A) **Under Age 65.** If the Covered Person is under the age of 65, the coverage available to such person is the coverage provided pursuant to the provisions of Article VI (Under Age 65 Coverage).

(B) **Age 65 or Older.** If the Covered Person is age 65 or older, the coverage available to such person is the coverage provided pursuant to the provisions of Article VII (Age 65 and Older Coverage).

(C) **Determination of Age.** For purposes of determining the coverage that is available under this Retiree Medical Plan, a Covered Person is considered to be age 65 as of the first day of the month in which he/she attains age 65.

(D) **Attaining Age 65 During Middle of Plan Year.** If a Covered Person attains age 65 during the middle of a Plan Year, the Covered Person shall no longer be covered under Article VI as of the first day of the month in which the Covered Person attains age 65. In this event, the Covered Person must instead be covered under the coverage provided pursuant to Article VII.

Section 5.02 Special Rule for Covered Retiree Age 65 or Older with Covered Dependents Under Age 65. If a Covered Retiree is age 65 or older but one or more of his/her Covered Dependents is under age 65, the following rules apply:

(A) The Covered Retiree and any Covered Dependents who are age 65 and older will be covered under the Age 65 and Older Coverage of this Retiree Medical Plan as set forth in Article VII. Premiums for this portion of the coverage shall be calculated as if these persons were the only persons being covered under this Retiree Medical Plan.

(B) Any Covered Dependents who are under age 65 will be covered under the Under Age 65 Coverage of this Retiree Medical Plan as set forth in Article VI. Premiums for this portion of the coverage shall be calculated as if these persons were the only persons being covered under this Retiree Medical Plan. For purposes of calculating premiums, the oldest of any such Covered Dependents shall be treated as if he/she is the Covered Retiree and the remaining Covered Dependents, if any, shall be treated as if they are Covered Dependents of the oldest such Covered Dependent.

(C) The total premium for the coverage being provided under this Retiree Medical Plan as a result of this Section 5.02 will be equal to the premium for the Under Age 65 Coverage plus the premium for the Age 65 and Older Coverage.
Section 5.03 Special Rule for Covered Retiree Under Age 65 with Covered Dependents Age 65 or Older. If a Covered Retiree is under age 65 but one or more of his/her Covered Dependents is age 65 or older, the following rules apply:

(A) The Covered Retiree and any Covered Dependents who are under age 65 will be covered under the Under Age 65 Coverage of this Retiree Medical Plan as set forth in Article VI. Premiums for this portion of the coverage shall be calculated as if these persons were the only persons being covered under this Retiree Medical Plan.

(B) Any Covered Dependents who are age 65 and older will be covered under the Age 65 and Older Coverage of this Retiree Medical Plan as set forth in Article VII. Premiums for this portion of the coverage shall be calculated as if these persons were the only persons being covered under this Retiree Medical Plan. For purposes of calculating premiums, the oldest of any such Covered Dependents shall be treated as if he/she is the Covered Retiree and the remaining Covered Dependents, if any, shall be treated as if they are the Covered Dependents of the oldest such Covered Dependent.

(C) The total premium for the coverage being provided under this Retiree Medical Plan will be equal to the premium for the Under Age 65 Coverage plus the premium for the Age 65 and Older Coverage.

Section 5.04 Special Rules for Certain Civil Service Retirees. A Covered Retiree participating in the Civil Service Retirement System (“Civil Service Retiree”), who is not enrolled in Medicare Part A, may be covered under the Under Age 65 Coverage of this Retiree Medical Plan. Such coverage will be secondary to Medicare. If and when the Civil Service Retiree does become enrolled in Medicare Part A and is approved for coverage by the Insurer, the Civil Service Retiree will no longer be eligible for coverage under the Under Age 65 Coverage of this Retiree Medical Plan but will instead be required to enroll in the Age 65 and Older Coverage if he/she wishes to continue his/her coverage under this Retiree Medical Plan.
ARTICLE VI
COVERAGE: MEDICAL BENEFITS FOR PERSONS UNDER AGE 65

Section 6.01 Medical Benefits. Medical benefits under this Article VI are identical to those described in, and shall be paid pursuant to the terms of, the current Benefit Description, which is attached to this Wrap Around Plan Document. The provisions of the Benefit Description, as it may be amended from time to time, are incorporated herein by reference and the rights and conditions with respect to the benefits payable under this Retiree Medical Plan shall be determined from the Benefit Description; provided, however, that should there be any contradictions between the Benefit Description and this document, this document will control.

Section 6.02 Election to Participate.

(A) Benefit Options. An Eligible Retiree may choose from multiple benefit options as set forth in the Benefit Description and the Benefit Schedules attached thereto. The election applies to the Eligible Retiree as well as to any Eligible Dependent(s) for whom coverage is elected.

(B) Enrollment/Status Change Forms. As set forth in Article IV, if an Eligible Retiree elects coverage under this Retiree Medical Plan (including coverage for his/her Eligible Dependent(s)), he/she must timely complete and return all requisite enrollment/status change forms to the Plan Administrator.

(C) Ability to Change Benefit Options. Covered Retirees make an annual decision regarding their medical coverage under this Retiree Medical Plan and, subject to the exceptions in Subsection (C)(1) and (C)(2) below, may change their benefit option only during the annual enrollment period, to be effective at the beginning of the next Plan Year. Benefit options may be changed outside of the annual enrollment period if:

(1) The Covered Retiree acquires a new (or newly) Eligible Dependent as set forth in Article IV; or

(2) The Covered Retiree elects coverage, pursuant to Section 4.08, for his/her Eligible Dependent who was previously covered another health insurance plan.

Section 6.03 Premiums for Coverage. The Covered Person is responsible for payment of the applicable premium for coverage under the Under Age 65 Coverage of this Retiree Medical Plan, subject to any subsidy, to which the Covered Person may be entitled. The amount of the applicable premium may change from time to time.
ARTICLE VII
COVERAGE: MEDICAL BENEFITS FOR PERSONS AGE 65 AND OLDER

Section 7.01 Medical Benefits. The benefits provided under this Article VII are identical to those described in, and shall be paid pursuant to the terms of, the individual Insurance Contract between the Insurer and the Covered Person who has elected coverage under such Insurance Contract pursuant to this Article VII. The provisions of the Insurance Contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by the Insurer. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Article VII shall be determined from the Insurance Contract. The Covered Person shall fully bear any and all risk of insolvency on the part of the Insurer.

Section 7.02 Effective Date of Age 65 and Older Coverage. The effective date of coverage for Covered Retirees and/or Covered Dependents in the Age 65 and Older Coverage of this Retiree Medical Plan is as follows:

(A) Previously Covered as part of Under Age 65 Coverage. A Covered Retiree or Covered Dependent who was previously covered as part of the Under Age 65 Coverage of this Retiree Medical Plan must elect coverage as part of the Age 65 and Older Coverage of this Retiree Medical Plan no later than the first day of the month in which such Covered Retiree or Covered Dependent attains age 65. If such coverage is timely elected, it will be effective on the first day of the month in which such Covered Retiree or Covered Dependent attains age 65.

(B) Retirement Date After Age 65. A Retiree who, at the time of his/her Retirement Date, is age 65 or older and who (i) satisfies the eligibility requirements for coverage set forth in Article III, and (ii) timely elects to enroll in this Retiree Medical Plan pursuant to Section 4.03, will be enrolled in the Age 65 and Older Coverage. Such coverage will be effective on the first day of the month or the sixteenth day of the month that is coincident with or next following such Eligible Retiree’s Retirement Date.

(C) Dependent Age 65 or Older at Time of Eligible Retiree’s Retirement Date. An Eligible Dependent who, at the time he/she is initially enrolled in this Retiree Medical Plan, is age 65 or older, will be enrolled in the Age 65 and Older Coverage. Such coverage will be effective as set forth in Part B of Article IV.

Section 7.03 Coverage Options under the Insurance Contract. Prior to attaining age 65, and at such other times as the Plan Administrator may designate, a Covered Person must select the coverage option under the Insurance Contract that he/she desires.

(A) Selection of Coverage Options. Each Covered Person must choose his/her own coverage option.
(B) **Underwriting Requirement.** There is no underwriting requirement when a Covered Person first becomes eligible for coverage under this Article VII. Any other underwriting requirements are reflected in the underlying Insurance Contract.

**Section 7.04 Premiums for Coverage.** The premiums for coverage will be determined by the Insurer and may change from time to time. If a Covered Person enrolls in this Retiree Medical Plan after attaining age 65, he/she may pay a higher premium for coverage. The Covered Person is responsible for payment of the applicable premium, reduced by the subsidy, if any, to which he/she is entitled.

**Section 7.05 Claims Administrator.** The Claims Administrator for all benefits payable under this Article VII is the Insurer. As Claims Administrator, the Insurer has full discretionary authority to make all determinations regarding the payment of benefit Claims in accordance with the terms of the Insurance Contract. All decisions of the Claims Administrator shall be final and binding.

**Section 7.06 Coordination of Benefits.** The Coordination of Benefits provisions in the Insurance Contract are hereby incorporated by reference.

**Section 7.07 Third Party Liability/Subrogation Provisions.** The third party liability and subrogation provisions in the Insurance Contract are hereby incorporated by reference.
ARTICLE VIII
HIPAA MEDICAL PRIVACY AND SECURITY

PART I – PREAMBLE

Section 8.01 Purpose and Effective Date. This HIPAA Medical Privacy and Security Article is adopted in response to the provisions of the Medical Privacy and Security Regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Section 8.02 Application of Amendment. This Article shall supersede the provisions of the Retiree Medical Plan to the extent those provisions are inconsistent with the provisions of this Article.

Section 8.03 Relationship to Other Group Health Plans. The Retiree Medical Plan is part of an “organized health care arrangement” (“OHCA”) with the following plans maintained by the Employer:

(A) The Farm Credit Foundations Dental Plan; and
(B) The Farm Credit Foundations Medical Plan; and
(C) The Health Flexible Spending Account that is a component of the Farm Credit Foundations Flexible Benefits Plan.

The plans that are part of the OHCA as set forth above may be collectively referred to in this Article VIII as the “Group Health Plan.”

PART II – DISCLOSURE OF PHI TO THE EMPLOYER

Section 8.04 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by Part II of this Article VIII, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose Protected Health Information or electronic Protected Health Information to the Employer.

Section 8.05 Definitions. For purposes of this Article VIII, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in 45 C.F.R. Parts 160 and 164.

(A) “Breach” means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use or disclosure are excluded from the definition of a “breach.”
(1) Any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of the Group Health Plan or Business Associate (as defined in 45 C.F.R. § 160.103) if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such employee or individual, respectively, with the Group Health Plan or the Business Associate, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the Privacy or Security Rules;

(2) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan or Business Associate to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the Privacy or Security Rules; and

(3) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.

(B) “De-identified Health Information” means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed. Information that must be removed, pursuant to this section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone, and fax numbers, and Social Security numbers.

(C) “Electronic Media” means

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media includes, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
(D) “Electronic Protected Health Information” (‘e-PHI”) means PHI that is transmitted or maintained in electronic media.

(E) “Individually Identifiable Health Information” means information for which each of the following conditions is met:

1. The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse; and

2. The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and

3. The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.

(F) “Plan Administration Functions” means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan that is not part of the same OHCA as the Retiree Medical Plan.

(G) “Protected Health Information” (“PHI”) means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.

(H) “Security Incident” (as defined in 45 C.F.R. § 164.304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(I) “Security Rule” shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Parts 160 and 164, subpart C.

(J) “Summary Health Information” means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed, except that geographical locations may be described using a five digit ZIP code.

(K) “Unsecured Protected Health Information” (“Unsecured PHI”) means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.
Section 8.06 Enrollment/Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been unenrolled in, the medical coverage provided under the Group Health Plan.

Section 8.07 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

(A) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any Business Associates of the Group Health Plan; and

(B) Overseeing the adjudication of benefit Claims, including the responsibility to provide coverage upon the initial submission of Claims and the disposition of any appeals that are filed with respect to Claims that are denied in whole or in part; and

(C) Overseeing the coordination of benefits and pursuing and/or responding to Claims for subrogation; and

(D) Conducting cost management and planning related analysis, including the forecasting of expected healthcare costs based on current utilization of benefits; and

(E) Detecting fraud or abuse; and

(F) Determining whether charges for services are appropriate or justified; and

(G) Requesting underwriting or premium rating and other activities related to the creation, renewal, or replacement of a contract of health insurance; and

(H) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part; and

(I) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate; and

(J) Providing assistance, upon request, to Covered Persons in addressing and resolving problems that they may encounter with the approval and payment of Claims that have been submitted on their behalf; and
(K) Reporting corporate finances with respect to current and projected healthcare costs; and

(L) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and

(M) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section 8.07 is subject to the provisions of Section 8.08.

**Section 8.08 Conditions for Disclosure for Plan Administration Functions.** With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 8.07, the Employer agrees to do the following:

(A) Not use or further disclose PHI or e-PHI other than as permitted or required by the Group Health Plan document or as required by law; and

(B) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI; and

(C) Not to use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer; and

(D) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. This includes reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s) and the Department of Health and Human Services (the “HHS”) may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications; and

(E) Restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out of pocket in full; and
(F) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual’s right to access his/her own information as that right is set forth in 45 C.F.R. § 164.524; and

(G) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by 45 C.F.R. § 164.526; and

(H) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual’s PHI or e-PHI in accordance with and to the extent required by 45 C.F.R. § 164.528; and

(I) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA’s medical privacy and security requirements; and

(J) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(K) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:

   (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI; and

   (2) Ensure that any agents (including subcontractors) to whom it provides such e-PHI agree to implement reasonable and appropriate security measures to protect the information; and

   (3) Report to the Group Health Plan any Security Incident of which it becomes aware.

(L) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III of this Article VIII; and

(M) Provide a certification to the Group Health Plan as required by Section 8.09.
Section 8.09 Certification by the Employer. In the absence of an authorization, the Group Health Plan may not disclose any Protected Health Information to the Employer unless and until the Group Health Plan is in receipt of a certification from the Employer. The Employer must certify in the certification that the Group Health Plan has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii). The Employer must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section 8.08 of Part II of this Article VIII.

PART III – ADMINISTRATIVE SAFEGUARDS

Section 8.10 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III of Article VIII. The Employer will ensure that the provisions of this Part III are supported by reasonable and appropriate security measures to the extent that the “authorized employees” have access to e-PHI. Further, this Part III of Article VIII does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 8.11 Authorized Employees. The following Employees (“Authorized Employees”) are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to Covered Persons: (a) those Employees of the Employer who have the responsibility for administering the benefit programs of the Employer, including, but not limited to, all Employees who serve on or are appointed by the Trust Committee and all Employees of Farm Credit Foundations; (b) members of the Trust Committee; and (c) the Internal Counsel of the Trust Committee and his/her support staff in the legal department, but only for the limited purposes of ensuring investigation of and responding to complaints alleging violations of the policies and procedures established by the Employer.

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an Employee in the information technology department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel’s support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.
Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy and security rules and shall comply fully with the Group Health Plan’s policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 8.12 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 8.13 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III of Article VIII, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.
ARTICLE IX
ADMINISTRATION OF THE RETIREE MEDICAL PLAN

Section 9.01  Plan Administrator. The Plan Administrator is the Trust Committee. The Plan Administrator is responsible for the administration of the Retiree Medical Plan. The Plan Administrator has the full discretionary authority to administer the Retiree Medical Plan, subject to the requirements of law. Except as otherwise provided by law or otherwise delegated in this Retiree Medical Plan, all decisions of the Plan Administrator are final and binding on all parties. For this purpose, the Plan Administrator, in addition to such other powers as the law may provide, has the power to:

(A) Establish rules and procedures for the purpose of the administration of this Retiree Medical Plan; and

(B) Require each Covered Person to supply such information and sign such documents as may be necessary to administer this Retiree Medical Plan; and

(D) Interpret, construe, and carry out the provisions of the Retiree Medical Plan; and

(E) Render decisions on the administration of the Retiree Medical Plan, including factual and legal determinations as to whether any individual is entitled to receive any benefit under the terms of this Retiree Medical Plan; and

(D) Appoint such agents, attorneys, accountants and consultants, staff, and any other person required for proper administration of the Retiree Medical Plan.

The Plan Administrator shall keep all books, accounts, records, and other data as may be necessary for the proper administration of the Retiree Medical Plan.

Section 9.02  Plan Must Be Nondiscriminatory. The Plan Administrator will administer this Retiree Medical Plan in a nondiscriminatory manner so that all persons similarly situated will receive substantially similar treatment.
ARTICLE X
CLAIMS PROCEDURES FOR SELF-FUNDED MEDICAL AND
PRESCRIPTION DRUG BENEFIT OPTIONS – UNDER AGE 65 COVERAGE

PART I – GENERAL PROVISIONS

Section 10.01 Claims Administrator. In the Under Age 65 Coverage of this Retiree Medical Plan, the Claims Administrator with respect to any Claim for benefits (other than prescription coverage) under a self-funded PPO option – as set forth in the Benefit Description – is BlueCross BlueShield of Illinois, P.O. Box 805107, Chicago, IL, 60680-4112. (Its Internet address is www.bcbsil.com/ foundations.) The Claims Administrator with respect to any Claim for prescription benefits is CVS Caremark, P.O. Box 686005, San Antonio, TX, 78265-6005. (Its internet address is www.caremark.com.) Both Claims Administrators may be contacted by telephone at 1-866-563-8366.

Fiduciary responsibility for Claims administration is delegated to the applicable Claims Administrator as provided in ERISA § 405(c) just as though the Retiree Medical Plan were not a “governmental plan,” but a plan fully subject to Title I of ERISA as to the duties and responsibilities of the Claims Administrator. The Claims Administrator has the ultimate responsibility for the final determination of all Claims made under the Retiree Medical Plan except to the extent, and only to the extent, that a Claim requires a determination to be made as to whether a given individual was eligible to be, and in fact was, covered under the Retiree Medical Plan at the time the Claim was incurred. The Claims Administrator shall have the sole and exclusive discretion and power to grant and/or deny all Claims for benefits. No finding, decision, and/or determination made by the Claims Administrator shall be disturbed unless the Claims Administrator has acted in an arbitrary or capricious manner.

Section 10.02 Duties of the Claims Administrator. The applicable Claims Administrator shall have the discretionary power and authority to perform the following duties and responsibilities:

(A) Receive Claims for benefits and render decisions with respect to either medical or prescription Claims under the Retiree Medical Plan; and

(B) Compute the amounts payable for any Participant or other person in accordance with the provisions of the Retiree Medical Plan, determine the manner and time of payment, and determine and authorize the person or persons to whom such payments will be paid; and

(C) Make discretionary interpretations regarding the terms relating to administration of Claims under the Retiree Medical Plan, its interpretations to be final and conclusive on all persons claiming benefits under the Retiree Medical Plan; and

(D) Make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of Claims under the Retiree Medical Plan; and
(E) Adopt such rules and procedures relating to the administration of Claims as it deems necessary or desirable; and

(F) Be responsible for all Claims administration reporting and disclosure requirements for the Retiree Medical Plan under the law; and

(G) Receive from the Employer, Employees, participants and other persons such information as shall be necessary for the proper administration of Claims under the Retiree Medical Plan; and

(H) Maintain all Claims administration records of the Retiree Medical Plan.

The applicable Claims Administrator shall also handle appeals for benefits in accordance with this Article X and the applicable Benefit Schedule referenced in the Benefit Description.

PART II – CLAIMS FOR MEDICAL BENEFITS (OTHER THAN PRESCRIPTIONS)

Section 10.03 Claims for Medical Benefits (Other Than Prescriptions). The Claims procedures outlined in Part II of this Article X shall apply to all Claims for medical benefits and services other than prescription benefits. Prescription benefit Claims procedures are governed by Part III of this Article X.

Section 10.04 How to File a Claim.

(A) Claim Filed by Hospital or Physician. In order to obtain benefits under this Retiree Medical Plan, a Claim must be filed with the Claims Administrator. To file a Claim, the Covered Person must show his/her ID card to the Hospital or Physician (or other Provider) who is providing the service. The Hospital or Physician (or other Provider) shall file the Claim on behalf of the Covered Person. The Covered Person shall have the responsibility to ensure that the necessary Claim information has been provided to the Claims Administrator.

The Claim shall be processed by the Claims Administrator when it receives the Claim. The benefit payment shall be sent directly to the Hospital or Physician. The Claims Administrator shall provide the Covered Person a statement informing him/her of the amount of the Claim paid on his/her behalf. If necessary, the Claims Administrator shall send the payment directly to the Covered Person or, if applicable, in the case of a “qualified medical child support order,” to the designated representative as it appears on the Claims Administrator’s records.

(B) Exception to Filing By Hospital or Physician. Under certain circumstances, Claims must be filed directly by the Covered Person. The Covered Person must file his/her own Claim if the Covered Person receives services or supplies from a non-PPO provider or Hospital or from Providers other than a Hospital or Physician. For example, if the Covered Person has ambulance expenses, he/she must file his/her own Claim. Such Claim must be filed as follows:
(1) **Claim Form.** A Claim form must be completed. Claim forms are available from the Claims Administrator’s office; and

(2) **Copies of Bills.** Copies of all bills to be considered for benefits must be attached to the Claim form. The bills must include the Provider’s name and address, the patient’s name, the diagnosis, the date of service and a description of the service and the Claim Charge; and

(3) **Mailing Address.** The completed Claim form with attachments must be mailed to BlueCross BlueShield of Illinois, P.O. Box 805107, Chicago, Illinois 60680-4112.

**Section 10.05 Claims Procedures.** Claims made for benefits, and any appeals from the denial of such Claims under the Retiree Medical Plan, shall be processed in accordance with the claims procedures set forth in the Medical Claims Procedures of the Benefit Schedule.

**PART III – CLAIMS FOR PRESCRIPTION BENEFITS**

**Section 10.06 Claims for Prescriptions Benefits.** The procedures outlined in Part III of this Article X shall apply only to Claims for prescription benefits. Claims for other medical benefits and services are governed by Part I of this Article X.

**Section 10.07 How to File a Claim.** In order to obtain prescription benefits under this Retiree Medical Plan, a Claim must be filed with the Claims Administrator. The procedures for filing the Claim with the Claims Administrator vary, depending on whether the Covered Person’s prescription is filled at a Mail Order Pharmacy, a Network Retail Pharmacy, or a Non-Network Retail Pharmacy (as those terms are defined in the Benefit Schedules).

(A) **Mail Order Pharmacy.** If a Covered Person chooses to have his/her prescription filled through a Mail Order Pharmacy, he/she must complete a Participant Profile/Order Form, which shall be made available by the Plan Administrator. This form must then be sent, along with any required documents and any applicable co-payment or co-insurance, to the Claims Administrator’s Mail Order Pharmacy at the following address: CVS Caremark, P.O. Box 659529, San Antonio, Texas, 78265-9529. The Claims Administrator shall process the Claim after the Mail Order Pharmacy has filled the prescription.

(B) **Network Retail Pharmacy.** If a Covered Person chooses to have his/her Prescription filled at a Network Retail Pharmacy, the Covered Person must present his/her Medical Plan identification card to the Network Retail Pharmacy at the time of purchase. After the Covered Person has paid any applicable co-payment or co-insurance, the Network Retail Pharmacy will file a Claim on the Covered Person’s behalf. The Claims Administrator shall process the Claim after receiving it from the Network Retail Pharmacy.
If the Covered Person’s Prescription is filled at a Network Retail Pharmacy, but the Covered Person fails to present his/her Medical Plan identification card at the time of purchase, the Covered Person must pay the full cost of the Prescription to the Network Retail Pharmacy and then file a Claim for reimbursement with the Claims Administrator.

(C) **Non-Network Retail Pharmacy.** If the Covered Person chooses to have his/her Prescription filled at a Non-Network Retail Pharmacy, the Covered Person must pay the full cost of the Prescription to the Non-Network Retail Pharmacy and then file a Claim for reimbursement with the Claims Administrator.

(D) **Claim Reimbursement Submissions.** A Covered Person seeking reimbursement for Prescription benefits from the Claims Administrator must complete a Prescription Drug Claim form and return it to the Claims Administrator.

(1) **Claim Forms.** Prescription Drug Claim forms shall be made available by the Claims Administrator.

(2) **Required Receipts.** The Prescription Drug Claim form must be accompanied by a receipt for each Prescription medication. Each receipt must show: the patient’s name, the Prescription number, the Pharmacy name and address, the name and strength of the drug, the quantity of the drug, an indication whether the prescribing Physician directed that the Prescription be dispensed as written, the Physician’s name or DEA number, the date of purchase, and the total charge for the Prescription.

(3) **Mailing Address.** The completed Prescription Drug Claim Form must be mailed to CVS Caremark, Inc., P.O. Box 686005, San Antonio, Texas, 78268-6005.

**Section 10.08 Claims Procedures.** Claims made for prescription benefits, and any appeals from the denial of such Claims, under the Retiree Medical Plan shall be processed in accordance with the claims procedures set forth in the Prescription Claims Procedures of the Benefit Schedule.

**PART IV – LITIGATION OF DENIED CLAIM APPEALS**

**Section 10.09 Litigation of Claim.** Prior to initiating legal action concerning a Claim for benefits in any state or federal court against this Retiree Medical Plan, any trust used in conjunction with this Retiree Medical Plan, and/or the Plan Administrator, a claimant must first exhaust the administrative remedies provided by the Claims Administrator in accordance with this Article X. If the Claims Administrator, acting pursuant to the Retiree Medical Plan’s written Claims procedure, makes a final written determination denying a Claim, the claimant, to preserve the Claim, must file an action with respect to the denied Claim not later than 180 days following the date of the Claims Administrator’s final determination.
ARTICLE XI

[RESERVED]
ARTICLE XII
CLAIMS PROCEDURES FOR AGE 65 AND OLDER COVERAGE

Section 12.01 Claims Procedures. The claims procedures for coverage under the Age 65 and Older Coverage of this Retiree Medical Plan are set forth in the individual Insurance Contract issued by the Insurer to the Covered Retiree and/or his/her Covered Dependent(s).
ARTICLE XIII
SUBROGATION AND REIMBURSEMENT OF THE RETIREE MEDICAL PLAN

Section 13.01 Age 65 and Older Coverage. The subrogation and reimbursement provisions related to the Age 65 and Older Coverage of this Retiree Medical Plan are set forth in the individual Insurance Contract issued by the Insurer to the Covered Retiree and/or his/her Covered Dependent(s).

Section 13.02 Under Age 65 Coverage – Self-Funded PPO Options. The subrogation and reimbursement provisions related to the self-funded PPO options in the Under Age 65 Coverage of this Retiree Medical Plan are set forth in this Article XIII.

Section 13.03 Subrogation/Reimbursement Rights of the Plan.

(A) Plan’s Right to Subrogation. The Retiree Medical Plan shall be subrogated to all rights that a Covered Person or his/her assignee has against any person, firm, corporation, insurer (including, but not limited to, worker’s compensation or any other occupational disease act or law, uninsured motorist coverage, and business/homeowners medical liability insurance coverage or payments) or other entity with respect to any and all benefits previously paid by the Retiree Medical Plan, or on behalf of the Retiree Medical Plan, to such individual for any injuries, expenses, or loss which may be caused by the negligence or wrongful act of a third party.

(B) Plan’s Right to Reimbursement. A Covered Person or his/her assignee agrees to include the amounts of any and all benefits paid by the Retiree Medical Plan (or any amount considered to be for future medical expenses) in any Claim such individual brings against any person, firm, corporation, insurer, or other entity. Upon any recovery made by a Covered Person or his/her assignee from any source of compensation, whether by judgment, settlement, compromise, or otherwise, the Retiree Medical Plan shall have first lien upon such recovery and be entitled to immediate reimbursement to the extent of any and all benefits paid by the Retiree Medical Plan.

Section 13.04 Amount of Recovery. The Retiree Medical Plan has the right to recovery, whether by subrogation or reimbursement, for any and all benefits paid by the Retiree Medical Plan. The amount due shall not be reduced due to attorney’s fees and/or costs incurred in pursuing a Claim or reimbursement. In addition, these rights take priority over the Covered Person’s, or his/her assignee’s, right to be made whole.

Section 13.05 Condition of Payment. By accepting benefits from the Retiree Medical Plan, a Covered Person or his/her assignee agrees to the following:

(A) The Retiree Medical Plan may require a Covered Person, assignee, or someone legally qualified and authorized to act for such person, to agree to Sections 13.03 and 13.04 in writing and to execute any and all other instruments reasonably necessary for the Retiree Medical Plan to assert its rights under these Sections; and
(B) Any amounts recovered by such individual or by the Retiree Medical Plan by judgment, settlement, or otherwise will be applied first to reimburse the Retiree Medical Plan; and

(C) The Retiree Medical Plan shall be subrogated to all Claims, demands, actions, and rights of recovery against a third party to the extent of any and all payments made by the Retiree Medical Plan; and

(D) At the Retiree Medical Plan's request, a Covered Person or his/her assignee must take any action, give information, and/or execute instruments required by the Retiree Medical Plan, in its discretion, in order to aid the Retiree Medical Plan in its enforcement of its rights of recovery, reimbursement, and subrogation. If such individual fails to comply with such requests, the Retiree Medical Plan may withhold benefits, services, payments, or credits due under the Retiree Medical Plan.
ARTICLE XIV
TERMINATION AND AMENDMENT OF THE RETIREE MEDICAL PLAN

Section 14.01 Termination and Amendment. The Plan Sponsor Committee may amend or terminate this Retiree Medical Plan at any time in accordance with the procedures established by the Administrative Agreement, which procedures are hereby incorporated by reference. Any approved change to the Retiree Medical Plan shall be made through a written instrument. Upon termination of this Retiree Medical Plan, the Employer shall give notice of the termination to all individuals then receiving benefits under this Retiree Medical Plan and any other affected person.
ARTICLE XV
MISCELLANEOUS

Section 15.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 15.02 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any individual employed by an Employer who is carrying out his/her responsibilities within the scope of his/her job duties and to whom fiduciary responsibility with respect to this Retiree Medical Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this Retiree Medical Plan or under his/her job duties related to this Retiree Medical Plan. This indemnification does not cover such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person, provided this paragraph shall not limit any indemnification of the Employee pursuant to any indemnification provisions of the bylaws of the Employer of the Employee or pursuant to any indemnification insurance held by such Employer.

Section 15.03 Information. The Plan Administrator may require each Covered Person to supply such information and sign such documents as may be necessary to implement this Retiree Medical Plan.

Section 15.04 Legal Service. Process can be served on the Retiree Medical Plan by directing such legal service to the Claims Administrator and/or the Plan Administrator.

Section 15.05 Limitation of Rights. Neither the establishment of this Retiree Medical Plan, nor any amendment, nor the payment of any benefits gives any Covered Person or any other person a legal or equitable right against the Employer or the Plan Administrator, nor any rights of continued employment.

Section 15.06 Limitation on Liability. A Retiree Medical Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Retiree Medical Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 15.07 Named Fiduciary. The named fiduciary of this Retiree Medical Plan shall be the Trust Committee. The Trust Committee shall have complete authority to control and manage the operation and administration of this Retiree Medical Plan. If so designated in a contract between the Trust Committee and a Claims Administrator, the Claims Administrator shall also be a named fiduciary of this Retiree Medical Plan to the extent designated in such contract. In addition, the Insurer providing and making benefit payments for a particular insured benefit shall be named fiduciary of this Retiree Medical Plan with respect to that benefit.
Section 15.08 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Covered Person under this Retiree Medical Plan will be excludable from the Covered Person’s gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Covered Person. It shall be the obligation of each Covered Person to determine whether each payment under the Retiree Medical Plan is excludable from the Covered Person’s gross income for Federal and state income tax purposes, and to notify the Employer if the Covered Person has reason to believe that any such payment is not so excludable.

Section 15.09 Nonalienation of Benefits. Benefits payable under this Retiree Medical Plan are not subject in any manner to transfer or assignment, unless such benefits are transferred or assigned (a) for the purpose of providing payment for services provided under the terms of this Retiree Medical Plan, and/or (b) as expressly permitted under the terms of this Retiree Medical Plan; any attempt to transfer, assign, or otherwise dispose of any right to benefits payable under this Retiree Medical Plan, is void. The Employer is not in any manner liable for, nor subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under this Retiree Medical Plan.

Section 15.10 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in this Retiree Medical Plan due to the person’s classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Retiree Medical Plan on a prospective basis only. No person shall be allowed to enter the Retiree Medical Plan on a retroactive basis.

Section 15.11 Rights to Employer’s Assets. No Covered Person or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Retiree Medical Plan, and then only to the extent of the benefits payable under the Retiree Medical Plan to such Covered Person or beneficiary. The Employer will make all payments of benefits this Retiree Medical Plan provides solely from the assets of the Employer, and the Plan Administrator is not liable for payment of benefits in any manner.

Section 15.12 Source of Funds. The Retiree Medical Plan shall be funded by direct payments from the Farm Credit Foundations Welfare Benefit Trust. The trust shall be funded by the Employer, the Retiree and/or their Covered Dependents subject to all of the provisions of this Retiree Medical Plan.

Section 15.13 State Law. The laws of the State of Delaware will determine all questions arising with respect to the provisions of this Retiree Medical Plan except to the extent superseded by Federal law.

Section 15.14 Plan Sponsor for Purposes of PCOR Fee. In accordance with, and as permitted by, Treasury Regulation § 46.4376-1(c)(2)(i)(G), Farm Credit Foundations is designated as the “plan sponsor” for purposes of the payment of the fee imposed under Code § 4376 on the plan sponsor of a self-insured group health plan.
The medical care benefits offered under the Under Age 65 Coverage of this Retiree Medical Plan are described in this Benefit Description and attached schedules and are provided pursuant to Section 6.01 of the Wrap Around Plan Document. This Benefit Description is a part of and incorporated into the Wrap Around Plan Document of the Retiree Medical Plan. This Benefit Description incorporates by reference the terms and conditions of each benefit option listed below and set forth in an attached schedule.

All Eligible Retirees may choose to participate in one of the following three self-funded benefit options:

**Consumer Choice Option 1** (Group No. 201713 and 201738 (WI))
- Everyone except Wisconsin employees
- Wisconsin employees

**Consumer Choice Option 2** (Group Nos. 201716 and 201739 (WI))
- Everyone except Wisconsin employees
- Wisconsin employees

**Prescription Coverage** (Group No.1385)
- Everyone

Covered Retirees and their Covered Dependents will only receive benefits under the benefit option in which they are enrolled, according to the terms and conditions of the applicable schedule. However, unless otherwise provided in the Wrap Around Plan Document, the following provisions are addressed in the Wrap Around Plan Document and not in the benefit options:

- Definitions not contained in the benefit option;
- Eligibility and participation in the Retiree Medical Plan;
- Time and duration of coverage;
- Continuation of coverage;
- HIPAA medical privacy;
- Plan Administration;
- Subrogation / Reimbursement rights of the Retiree Medical Plan;
- Termination and amendment of the Retiree Medical Plan; and
- Other miscellaneous provisions.
BENEFIT SCHEDULE A

Farm Credit Foundations
Consumer Choice Option 1
(Group No. 201713 and 201738(WI))
Schedule A-1
(Everyone except WI employees)

(Blue Cross Blue Shield of Illinois)
Your Health Care Benefit Program

Farm Credit Foundations
Retiree Consumer Choice 1
201713

Administered by:

BlueCross BlueShield of Illinois
A message from

Farm Credit Foundations

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

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

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Retiree Benefits Department.

Sincerely,

Farm Credit Foundations
NOTICE

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

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

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

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

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

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.
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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 booklet.

THE UTILIZATION REVIEW PROGRAM

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

Lifetime Maximum for all Benefits

- Unlimited

Individual Coverage Deductible**

- $1,500 per benefit period

Family Coverage Deductible**

- $3,000 per benefit period

Individual Coverage Out-of-Pocket Expense Limit**

- Participating Provider: $3,000 per benefit period
- Non-Participating Provider: $6,000 per benefit period
- Non-Administrator Provider: No limit

Family Coverage Out-of-Pocket Expense Limit**

- Participating Provider: $6,000 per benefit period
- Non-Participating Provider: $12,000 per benefit period
- Non-Administrator Provider: No limit

HOSPITAL BENEFITS

Payment level for Covered Services from a Participating Provider:

- Inpatient Covered Services: 80% of the Eligible Charge
- Outpatient Covered Services: 80% of the Eligible Charge

Payment level for Covered Services from a Non-Participating Provider:

- Inpatient Covered Services: 60% of the Eligible Charge
- Outpatient Covered Services: 60% of the Eligible Charge

Payment level for Covered Services from a Non-Administrator Provider:

- 100% of the Non-Participating Hospital Benefit Payment Level
Hospital Emergency Care
— Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider 80% of the Eligible Charge
— Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider 80% of the Eligible Charge

BLUE DISTINCTION/
BLUE DISTINCTION PLUS

Transplants
— Blue Distinction Designated Center 100% of the Eligible Charge, no deductible
— Blue Distinction Plus Designated Center 100% of the Eligible Charge, no deductible
— Participating Provider 80% of the Eligible Charge
— Non-Participating Provider 60% of the Eligible Charge

PHYSICIAN BENEFITS
Payment level for Surgical/ Medical Covered Services
— Participating Provider 80% of the Maximum Allowance
— Non-Participating Provider 60% of the Maximum Allowance
Payment level for Emergency Accident Care 80% of the Maximum Allowance
Payment level for Emergency Medical Care 80% of the Maximum Allowance

OTHER COVERED SERVICES
Payment level 80% of the Eligible Charge or Maximum Allowance
HEARING BENEFITS

Hearing examination 80% of the Claim Charge

Hearing Aids Maximum $1,500 (every 36 month)

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

**Should the Federal Government adjust the Deductible for High Deductible Plans as defined by the Internal Revenue Service, the Deductible amount in this benefit booklet will be adjusted accordingly.**
DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

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

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

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

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

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

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

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE.....means the amount that represents the billed charges from the majority of the ambulance providers in the Chicago metro area, as submitted to the Claim Administrator.
AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

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

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

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

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse and is operating within the scope of such license; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.
A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

CHIROPRACTOR.....means a duly licensed chiropractor and is operating within the scope of his or her license.

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

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

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

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

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

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

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

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

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

A “Participating Clinical Social Worker” means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

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.).

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

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

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

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

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

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

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

(i) A group health plan.

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

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

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

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

(vi) A medical care program of the Indian Health Service or of a tribal organization.
(vii) A State health benefits risk pool.

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

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

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

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

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

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

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

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans and positron emission tomography (PET) scans.

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

An “Administrator Dialysis Facility” means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.
A “Non-Administrator Dialysis Facility” means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

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

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

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other’s common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner’s life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner’s will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

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

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

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

(i) the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider’s Billed Charges, and (b) an amount determined by the Claim Administrator to be approximately 300% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider’s Billed Charges and (b) an amount determined by the Claim Administrator to be 300% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the Maximum Allowance cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 300% of the Provider’s Billed Charges (unless otherwise required by applicable law or arrangement with the Non-Participating Provider), provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to you.

In addition to the foregoing, the Eligible Charge will be subject in all respects to the Claim Administrator’s Claim Payment rules, edit and methodologies re-
Regardless of the Provider’s status as a Participating Provider or Non-Participating Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed charge for such Covered Services (unless otherwise required by applicable law or arrangement with the Non-Participating Provider).

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

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating Provider’s standard billed charge for such Covered Service (unless otherwise required by applicable law or arrangement with the Non-Participating Provider). (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an retiree of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

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

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

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

(ii) serious impairment to bodily functions; or

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

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

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

EMPLOYER.....means the company with which you are employed.

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

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

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

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

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

Although a Physician or Professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort. The Claim Administrator still may determine such services or supplies to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational.

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

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

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

A “Participating Home Infusion Therapy Provider” means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

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

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

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

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

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

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

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

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

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

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

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

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

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

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

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

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

A “Participating Marriage and Family Therapist” means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance
will be the lesser of (unless otherwise required by applicable law or arrangement with Non-Participating Providers):

(i) the Provider’s billed charges, or;

(ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 300% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

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

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

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

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

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.
MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

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

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

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

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

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

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

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

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

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

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

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

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

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

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

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

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

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

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

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.
PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

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

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

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

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

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

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

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

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

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

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

PODIATRIST.....means a duly licensed podiatrist operating within the scope of his or her license.
PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this benefit booklet.

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

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

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

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.
REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of his or her certification.

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

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

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

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

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

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

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.
A “Participating Retail Health Clinic” means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

ROUTINE PATIENT COSTS.....means the cost for all items and services consistent with the coverage provided under this benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

(i) The investigational item, device, or service, itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

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

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

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

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

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

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

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

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

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.
TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

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

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

TRANSPLANT LODGING ELIGIBLE EXPENSE.....means the amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

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

VIRTUAL PROVIDER.....means a licensed Provider who has a written agreement with the Claim Administrator to provide diagnosis and treatment of injuries and illnesses through either i) interactive audio communication (via telephone or other similar technology) or ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology) to you at the time services are rendered, operating within the scope of such license.

VIRTUAL VISIT.....means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the VIRTUAL VISITS provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.
UTILIZATION REVIEW PROGRAM

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

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

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

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

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

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

- **Emergency Admission Review**

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

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

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

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

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

• Skilled Nursing Facility Preadmission Review

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

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

• Coordinated Home Care Program Preadmission Review

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

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

• Private Duty Nursing Service Review

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

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

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

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

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

LENGTH OF STAY/SERVICE REVIEW

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

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

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

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

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

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

Remember that the Claim Administrator’s Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

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

UTILIZATION REVIEW PROCEDURE

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

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

Upon receipt of the required information, the Claim Administrator:

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

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

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

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

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

FAILURE TO NOTIFY

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

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.
CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

The Claim Administrator’s Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Use Disorder. 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 may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below.

PREAUTHORIZATION REVIEW

• **Inpatient Hospital Preauthorization Review**

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

  In order to receive maximum benefits under this Health Care Plan, you must Preauthorize for your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit. Participating and Non-Participating Providers may call the Mental Health Unit Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

• **Residential Treatment Center Preauthorization Review**

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

  Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness or Substance Use Disorder is recommended by your physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Mental Health Unit. This call must be made at least one day prior to scheduling of the admission. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.
• Emergency Mental Illness or Substance Use Disorder Admission Review

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

In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may call the Mental Health Unit Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

• Partial Hospitalization Treatment Program Review

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

In order to receive maximum benefits under this Health Care Plan, you must notify the Mental Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Participating and Non-Participating Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

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

• Length of Stay/Service Review

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

Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.
An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary 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.

**MEDICALLY NECESSARY DETERMINATION**

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

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

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

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.
MENTAL HEALTH UNIT PROCEDURE

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

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

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

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit 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 Behavioral Health Practitioner 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 Behavioral Health Practitioner 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 Physician, you may request an appeal in writing as outlined below.
Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

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

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

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

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

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

FAILURE TO PREAUTHORIZE OR NOTIFY

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

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this benefit booklet, 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 the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.
MEDICARE ELIGIBLE MEMBERS
The provisions of the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.
THE PARTICIPATING PROVIDER OPTION

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

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

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

YOUR BENEFIT PERIOD

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

YOUR DEDUCTIBLE

If you have Individual Coverage, each benefit period you must satisfy a $1,500 benefit program deductible before receiving benefits. After you have Claims for Covered Services in a benefit period which exceed this deductible amount, your benefits will begin.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has satisfied the family deductible amount of $3,000, it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the benefit program deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family deductible amount has been satisfied.

The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.
EXPENSES FOR HOSPITAL CARE ARE USUALLY THE BIGGEST OF ALL HEALTH CARE COSTS. YOUR HOSPITAL BENEFITS WILL HELP EASE THE FINANCIAL BURDEN OF THESE EXPENSIVE SERVICES. THIS SECTION OF YOUR BENEFIT BOOKLET TELLS YOU WHAT HOSPITAL SERVICES ARE COVERED AND HOW MUCH WILL BE PAID FOR EACH OF THESE SERVICES.

THE BENEFITS OF THIS SECTION ARE SUBJECT TO ALL OF THE TERMS AND CONDITIONS DESCRIBED IN THIS BENEFIT BOOKLET. PLEASE REFER TO THE DEFINITIONS, ELIGIBILITY AND EXCLUSIONS SECTIONS OF THIS BENEFIT BOOKLET FOR ADDITIONAL INFORMATION REGARDING ANY LIMITATIONS AND/OR SPECIAL CONDITIONS PERTAINING TO YOUR BENEFITS.

IN ADDITION, THE BENEFITS DESCRIBED IN THIS SECTION WILL BE PROVIDED ONLY WHEN YOU RECEIVE SERVICES ON OR AFTER YOUR COVERAGE DATE AND THEY ARE RENDERED UPON THE DIRECTION OR UNDER THE DIRECT CARE OF YOUR PHYSICIAN. SUCH SERVICES MUST BE MEDICALLY NECESSARY AND REGULARLY INCLUDED IN THE PROVIDER’S CHARGES.

REMEMBER, WHENEVER THE TERM “YOU” OR “YOUR” IS USED, WE ALSO MEAN ALL ELIGIBLE FAMILY MEMBERS WHO ARE COVERED UNDER FAMILY COVERAGE.

INPATIENT CARE

THE FOLLOWING ARE COVERED SERVICES WHEN YOU RECEIVE THEM AS AN INPATIENT IN A HOSPITAL.

INPATIENT COVERED SERVICES

1. Bed, board and general nursing care when you are in:
   - a semi-private room
   - a private room
   - an intensive care unit

2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

PREADMISSION TESTING

BENEFITS ARE PROVIDED FOR PREOPERATIVE TESTS GIVEN TO YOU AS AN OUTPATIENT TO PREPARE YOU FOR SURGERY WHICH YOU ARE SCHEDULED TO HAVE AS AN INPATIENT, PROVIDED THAT BENEFITS WOULD HAVE BEEN AVAILABLE TO YOU HAD YOU RECEIVED THESE TESTS AS AN INPATIENT IN A HOSPITAL. BENEFITS WILL NOT BE PROVIDED IF YOU CANCEL OR POSTPONE THE SURGERY.

THESE TESTS ARE CONSIDERED PART OF YOUR INPATIENT HOSPITAL SURGICAL STAY.

PARTIAL HOSPITALIZATION TREATMENT

BENEFITS ARE AVAILABLE FOR THIS PROGRAM ONLY IF IT IS AN ADMINISTRATOR PROGRAM. NO BENEFITS WILL BE PROVIDED FOR SERVICES RENDERED IN A PARTIAL HOSPITALIZATION TREATMENT PROGRAM WHICH HAS NOT BEEN APPROVED BY THE CLAIM ADMINISTRATOR.

COORDINATED HOME CARE

BENEFITS WILL BE PROVIDED FOR SERVICES UNDER A COORDINATED HOME CARE PROGRAM.
BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider
When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 80% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital’s rate for its most common type of room with two or more beds.

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.

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

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

Outpatient Hospital Covered Services
1. Surgery and any related Diagnostic Service received on the same day as the Surgery. In addition, benefits for Covered Services received for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care
8. Emergency Medical Care
9. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

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

**BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES**

**Participating Provider**

Benefits will be provided at 80% 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.

**Non-Administrator Provider**

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

**Emergency Care**

Benefits for Emergency Accident Care will be provided at 80% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Accident Care from either Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Accident Care will be subject to the Participating Provider program deductible.

Benefits for Emergency Medical Care will be provided at 80% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Medical Care from either Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Medical Care will be subject to the Participating Provider program deductible.

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

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

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

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

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

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

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

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

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

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

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

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

COVERED SERVICES

**Surgery**

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

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

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon’s office or Ambulatory Surgical Facility.
In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

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

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

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

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

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

- It manifested before the age of 22;

- It is likely to continue indefinitely; and

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

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

3. Sterilization Procedures (even if they are elective).
4. Gender reassignment—benefits for Covered Services for gender reassignment Surgery, including related services and supplies, will be provided the same as for any other condition.

**Medical Care**

Benefits are available for Medical Care visits when:

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

**Consultations**

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

**Diabetes Self-Management Training and Education**

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will also be provided for education programs that allow you to maintain a hemoglobin A1c level within the ranges identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management, operating within the scope of his/her license. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

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

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

**Emergency Accident Care**

**Emergency Medical Care**

**Electroconvulsive Therapy**

**Allergy Injections and Allergy Testing**
Chemotherapy

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

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.

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.

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.

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

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

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

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

**Acupuncture**—Benefits will be provided for acupuncture when rendered by a licensed acupuncturist.

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

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

**Orthotic Devices**

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

**Outpatient Contraceptive Services**

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

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.
Prosthetic Appliances
Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

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

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

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

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

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

Participating Provider
When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 80% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator’s benefit payment and the Provider’s charge to you.

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.
Emergency Care

Benefits for Emergency Accident Care will be provided at 80% 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 80% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

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

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

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

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

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

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

Participating Providers are:

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

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

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

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

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.
OTHER COVERED SERVICES

OTHER COVERED SERVICES

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

- The processing, transporting, storing, handling and administration of blood and blood components.

- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.

- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.

- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.

- Oxygen and its administration.

- Medical and surgical dressings, supplies, casts and splints.

- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia. Benefits for wigs will be limited to a lifetime maximum of $500.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.

Benefits for ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility) will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance after you have met your program deductible.

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

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

**Participating Providers are:**

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

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

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

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

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.
SPECIAL CONDITIONS AND PAYMENTS

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

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ 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 booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

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

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

— Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs.

— If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available,
your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

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

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

Blue Distinction Centers of Treatment (BDCT)

Blue Distinction is a designation awarded by Blue Cross and Blue Shield companies to health care facilities that have demonstrated expertise in delivering quality health care. At the core of the program are Blue Distinction Centers for Specialty Care. Blue Distinction Centers are recognized for providing distinguished care in the areas of:

• Transplants

The goal of Blue Distinction is to help you find specialty care while enabling and encouraging health care Providers to improve the overall quality and cost of care nationwide. Although your plan may require you to receive treatment at a Blue Distinction Center to get the highest level of benefits, you may still be covered at a non-Blue Distinction Center, but your out-of-pocket costs will usually be higher. Please refer to your Benefit Highlights section to see the payment levels for procedures performed at Blue Distinction Centers and procedures performed at other facilities. Blue Distinction benefit levels apply to facility benefits only. Travel and lodging benefits are the same as those outlined in the Human Organ Transplants section.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.
PREVENTIVE CARE SERVICES

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

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

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

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

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

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

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

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

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for the Copayment or Coinsurance for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment or Coinsurance for the office visit including the preventive health service.
Preventive Care Services for Adults (or others as specified):

1. Abdominal aortic aneurysm screening for men who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults over age 50
7. Depression screening
8. Type 2 diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
   - Hepatitis A
   - Hepatitis B
   - Herpes Zoster (Shingles)
   - Human papillomavirus
   - Influenza (Flu shot)
   - Measles, Mumps, Rubella
   - Meningococcal
   - Pneumococcal
   - Tetanus, Diphtheria, Pertussis
   - Varicella
12. Obesity screening and counseling
13. Sexually transmitted infections (STI) prevention
14. Tobacco use screening and cessation interventions for tobacco users
15. Syphilis screening for adults at higher risk
16. Physical Therapy to prevent falls in adults age 65 years and older who are at increased risk for falls
17. Hepatitis C virus (HCV) screening for adults at increased risk, and one time for everyone born 1945–1965
18. Hepatitis B virus screening for persons at high risk for infection
19. Counseling children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
20. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 and older

21. Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls

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

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

24. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history or CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking), and (c) a calculated 10-year CVD risk of 10% or greater

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

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

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

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

3. Breast cancer chemoprevention counseling for women at higher risk

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

5. Cervical cancer screening

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

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

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

9. Daily supplements for women who may become pregnant

10. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes

11. Gonorrhea screening for all women at higher risk

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

13. HIV screening and counseling for sexually active women and prenatal HIV testing
14. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
15. Osteoporosis screening for women over age 60, depending on risk factors
16. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
17. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
18. Sexually transmitted infections (STI) counseling for women
19. Syphilis screening for all pregnant women or other women at increased risk
20. Well-woman visits to obtain recommended preventive services
21. Breast cancer mammography screenings, including breast tomosynthesis and, if Medically Necessary, a screening MRI
22. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal
23. Aspirin use for pregnant women to prevent preeclampsia
24. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

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

1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Critical congenital heart defect screening for newborns
7. Major depression disorder (“MDD”) screening for adolescents
8. Development screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorder
10. Fluoride chemoprevention supplements for children without fluoride in their water source
11. Gonorrhoea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, weight and body mass index measurements
14. Hematocrit or hemoglobin screening
15. Hemoglobinopathies or sickle cell screening for all newborns
16. HIV screening for adolescents at higher risk
17. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
   - Hepatitis A
   - Hepatitis B
   - Human papillomavirus
   - Influenza (Flu shot)
   - Measles, Mumps, Rubella
   - Meningococcal
   - Pneumococcal
   - Tetanus, Diphtheria, Pertussis
   - Varicella
   - Haemophilus influenzae type b
   - Rotavirus
   - Inactivated Poliovirus
18. Lead screening for children at risk for exposure
19. Medical history for all children throughout development
20. Obesity screening and counseling
21. Oral health risk assessment for younger children up to ten years old
22. Phenylketonuria (PKU) screening for newborns
23. Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk
24. Tuberculin testing for children at higher risk of tuberculosis
25. Vision screening for all children
26. Autism screening
27. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
28. Newborn blood screening
29. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

The FDA-approved contraceptive drugs and devices currently covered under this benefit provision are listed on the Women’s Contraceptive Coverage List. This list is available on the Claim Administrator’s website at www.bcbsil.com and/or by contacting customer service at the toll-free number on your identification card. Benefits are not available under this benefit provision for
contraceptive drugs and devices not listed on the Women’s Contraceptive Coverage List. You may, however, have coverage under other sections of this benefit booklet, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The Women’s Contraceptive Coverage List and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

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

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

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

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

WELLNESS CARE

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

- Routine diagnostic medical procedures;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray.

Participating Provider

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

Non-Participating Provider

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

SKILLED NURSING FACILITY CARE
The following are Covered Services when you receive them in a Skilled Nursing Facility:

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 80% 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.

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

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services rendered 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.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT
Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center. Substance Use Disorder Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.
DETOXIFICATION

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

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

BARIATRIC SURGERY

Benefits for Covered Services received for bariatric Surgery will be provided under the HOSPITAL BENEFIT and PHYSICIAN BENEFIT sections of this benefit booklet, the same as for any other condition.

MATERNITY SERVICE

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

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

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours). Such an earlier discharge may only be provided if there is coverage and avail-
ability of a post-discharge Physician office visit or an in-home visit to verify the condition of the infant in the first 48 hours after discharge.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis of infertility.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility or the inability to attain or maintain a viable pregnancy, or sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments.

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

MASTECTOMY-RELATED SERVICES

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

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

VIRTUAL VISITS

Benefits will be provided for Covered Services described in this benefit booklet for the diagnosis and treatment of non-emergency medical injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room office visit. Benefits for such Covered Services will only be provided if you receive them via consultation with a Virtual Provider who has a specific written agreement with the Claim Administrator to provide Virtual Visits to you at the time services are rendered. For more information about this benefit, you may visit the Claim Administrator’s website at www.bcbsil.com or call customer service at the number on the back of your identification card.

Benefits for Covered Services you receive through a Virtual Visit from a Participating Virtual Provider are subject to a Copayment of $44 per visit and then will be provided at 100% of the Maximum Allowance, after you have met your program deductible.

Benefits will not be provided for services you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with the Claim Administrator to provide Virtual Visits.

Note: Not all medical conditions can be appropriately treated through Virtual Visits. The Virtual Provider will identify any condition for which treatment by an in-person Provider is necessary.

PAYMENT PROVISIONS

Lifetime Maximum

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

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $3,000, any additional eligible Claims for Participating Providers (except for those charges specifically excluded below)
during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

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

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

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or Non-Administrator Provider
- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

If you have Family Coverage and your family’s out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $6,000 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 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 you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $6,000, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

- the 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

• Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

If you have Family Coverage and your family’s out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $12,000 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 will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

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

Your Hospital coverage also includes benefits for Hospice Care Program Service.

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

The following services are covered under the Hospice Care Program:
1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are not covered under the Hospice Care Program:
1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

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

Benefit Payment for Hospice Care Program Services

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

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

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

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

In addition to the Definitions of this benefit booklet, the following definitions are applicable to this Benefit Section:

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

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

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

Benefit Period

Your hearing care benefit period begins on the first date a Covered Service is received after your Coverage Date and continues for a period of 36 consecutive months thereafter. Later benefit periods will begin on the first date a Covered Service is received following the expiration of your prior benefit period.

Covered Services

Benefits will be provided under this Benefit Section for the following:

- Audiometric Examination
- Hearing Aid Evaluation
- Conformity Evaluation
- Hearing Aids

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

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.
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.

**Benefit Payment for Hearing Care**

Benefits for hearing care Covered Services, other than audiometric examinations, will be payable at 80% of the Claim Charge after you have met your program deductible.

Benefits for audiometric examinations will be payable at 80% of the Eligible Charge or 80% of the Maximum Allowance after you have met your program deductible.

Benefits for hearing care Covered Services other than audiometric examinations will be provided up to a maximum of $1,500 every 36 months.
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 booklet (see provisions entitled “Medicare Eligible Covered Persons” in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet 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 Health Care 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 Health Care Plan.

When you have a Claim, you must send the Claim Administrator 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.
EXCLUSIONS - WHAT IS NOT COVERED

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

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

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

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician’s office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient’s condition.

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

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

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other 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.
The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

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

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

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

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

— Services or supplies that are not specifically mentioned in this benefit booklet.
— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers’ Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers’ Compensation Act according to the provisions of the Act.
— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

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

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

— Custodial Care Service.

— Long Term Care Service.

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

— Inpatient Private Duty Nursing Service.

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

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

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

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

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

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

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

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

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

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

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

— Immunizations, unless otherwise specified in this benefit booklet.

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

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability or mental disability.

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

— Hypnotism.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

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

— Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet.

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

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

— Elective abortions.

— Reversals of sterilization.

— Services and supplies rendered or provided for the treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination and all forms of in-vitro fertilization unless otherwise stated in the Benefit Highlights.

— Naprapathic services.
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 Health Care 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 Health Care Plan if no other group coverages were involved. It is your obligation to notify the Claim Administrator 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 Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.

2. When a dependent child receives services, the birthdays of the child’s parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent’s birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this “birthday” type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

— However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

— when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to
notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

In order to prevent duplicate payment of benefits for a Claim, the Claim 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 Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.
HOW TO FILE A CLAIM AND APPEALS PROCEDURES

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your identification card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator’s records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator’s office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider’s name and address, the patient’s name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:
   Blue Cross and Blue Shield of Illinois
   P. O. Box 805107
   Chicago, Illinois 60680-4112

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

Should you have any questions about filing Claims, ask your Retiree Benefits Department or call the Claim Administrator’s office.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

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

**If a Claim Is Denied or Not Paid in Full**

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

a. The reasons for determination;

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

c. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary;

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

e. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or external review);

f. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

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

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

j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant’s medical circumstances, if the determination was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
k. In the case of a determination of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such Claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator’s offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday. Customer service hours and operations are subject to change without notice.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, IL 60680-4112
1-800-538-8833 Toll-free phone

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your identification card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INQUIRIES AND COMPLAINTS

An “Inquiry” is a general request for information regarding claims, benefits, or membership.

A “Complaint” is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

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

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

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

When you contact customer service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of
receipt by customer service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted. If an Inquiry or Complaint is not resolved to your satisfaction, you may appeal to the Claim Administrator.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its retirees or a Provider.

The following is the contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For Complaints and general Inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
Consumer_complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Timing of Required Notices and Extensions

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

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

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

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

<table>
<thead>
<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
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<tbody>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>24 hours**</td>
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<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:</td>
<td>48 hours after receiving notice</td>
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*The Claim Administrator must notify you of the Claim determination (whether adverse or not):*

- if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than: 72 hours
- after receiving the completed Claim (if the initial Claim is incomplete), within: 48 hours

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

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

### Pre-Service Claims

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<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
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<tbody>
<tr>
<td>If your Claim is filed improperly, the Claim Administrator must notify you within:</td>
<td>5 days*</td>
</tr>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>15 days</td>
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<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:</td>
<td>45 days after receiving notice</td>
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*The Claim Administrator must notify you of the Claim determination (whether adverse or not):*

- if the initial Claim is complete, within: 15 days**
- after receiving the completed Claim (if the initial Claim is incomplete), within: 30 days

If you require post-stabilization care after an Emergency within: the time appropriate to the circumstance not to exceed one hour after the time of request
Notification may be oral unless the claimant requests written notification.

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

### Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
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<tbody>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>30 days</td>
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<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim</td>
<td>45 days after receiving notice</td>
</tr>
<tr>
<td>information to the Claim Administrator within:</td>
<td></td>
</tr>
</tbody>
</table>

The Claim Administrator must notify you of any adverse Claim determination:

| if the initial Claim is complete, within:                                                 | 30 days*                     |
| after receiving the completed Claim (if the initial Claim is incomplete), within:          | 45 days                      |

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

### Concurrent Care

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

### CLAIM APPEAL PROCEDURES - DEFINITIONS

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

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

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Claim Administrator will render a decision on the appeal within 24 hours after it receives the requested information, but not more than 72 hours from the appeal request.

Standard or Non-Urgent Appeals

The Claim Administrator will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

How to Appeal an Adverse Benefit Determination

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

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Under your health benefit plan, there is one level of internal appeal available to you. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your identification card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

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

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a Claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination.
In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, wish to file a complaint or wish to take up your matter with the IDOI, you may use either address below:

IDOI Consumer Division
320 W. Washington St.
Springfield, Illinois 62767
1-217-782-4515

or

IDOI Consumer Division
122 S. Michigan Ave., 19th Floor
Chicago, Illinois 60603
1-312-814-2420

Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.

Send a written appeal request to:
The Claim Administrator
Claim Review Section
P.O. Box 2401
Chicago, Illinois 60690

To file an appeal or if you have questions, please call 800-538-8833 (TTY/TDD:711, send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members (BAM) at bcbsil.com

During the course of your internal appeal(s), the Claim Administrator will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by the Claim Administrator in connection with the appealed Claim, as well as any new or additional rationale for a determination at the internal ap-
peals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. The Claim Administrator may extend the time period described in this benefit booklet for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial determination of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.

Timing of Non-Urgent Appeal Determinations

Upon receipt of a non-urgent concurrent pre-service or post-service appeal, the Claim Administrator will notify the party filing the appeal within five business days of all the information needed to review the appeal.

The Claim Administrator will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 calendar days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 30 calendar days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you have already received the service.

If the appeal is related to administrative matters or Complaints, the Claim Administrator will render a decision of a pre-service or post-service appeal as soon as practical, but in no event more than 60 business days after receipt of all required information.

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and a statement describing determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

4. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final determination on internal and external appeal;

5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative;

6. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

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

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

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

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

12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;

13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review;

14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the
Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a Provider appeal.

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

You may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the Complaint. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

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

**STANDARD EXTERNAL REVIEW**

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO). The external review is at no charge to the member.

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

A **“Final Internal Adverse Benefit Determination”** means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator’s internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt
of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:

a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

c. You have exhausted the Claim Administrator’s internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and

d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor’s Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the determination of benefits.
The IRO must provide the following:

a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

b. Timely notification to you or your authorized representative, in writing, of the request’s eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator’s internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned
IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;
(2) The attending health care professional’s recommendation;
(3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
(4) The terms of your plan to ensure that the IRO’s decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
(6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
(7) The opinion of the IRO’s clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous determination);
(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan’s decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. Request for expedited external review. Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STAN-
DARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator’s internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator’s contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

**EXHAUSTION**

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.
External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.
GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR’S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator’s contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider’s Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. 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 the Claim Administrator’s separate financial arrangements with Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital’s Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance
amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

BlueCard® Program

Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, the Claim Administrator will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever you access Covered Services outside the Claim Administrator’s service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

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

a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.
b. The provider has negotiated with the Host Blue a price of $80, even though the provider’s standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

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

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A,
BlueCard Program) made available to the Claim Administrator by the Host Blue.

Non-Participating Healthcare Providers Outside The Claim Administrator’s Service Area

a. Liability Calculation

(1) In General

When Covered Services are provided outside of the Claim Administrator’s service area by non-participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Booklet for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, the Claim Administrator may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then the Claim Administrator may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area (and described in Section (1) above); or

2. The following:

   (i) For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or

   (ii) For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

Value-Based Programs Negotiated Arrangements

If the Claim Administrator enters into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, Blue Cross and Blue Shield of Illinois will follow the same procedures
for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

**Blue Cross Blue Shield Global Core**

If you are outside the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

**Inpatient Services**

In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact the Claim Administrator to obtain Preauthorization for non-emergency Inpatient services.**

**Outpatient Services**

Outpatient Services are available for Emergency Care, Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

**Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider’s itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from the Plan, the Blue Cross Blue Shield Global Core Service Center or online at
www.bcbsglobalcore.com. If you need assistance with your Claim sub-
mission, you should call the Blue Cross Blue Shield Global Core Service
Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24
hours a day, seven days a week.

**Servicing Plans**

In some instances, the Claim Administrator has entered into agreements
with other Blue Cross and Blue Shield Plans (“Servicing Plans”) to pro-
vide, on the Claim Administrator’s behalf, Claim Payments and certain
administrative services for you. Under these agreements, the Claim Ad-
ministrator will reimburse each Servicing Plan for all Claim Payments
made on the Claim Administrator’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 the Claim Administrator for Claim Payments made by the Serv-
icing Plan and applicable service charges, and all benefit maximum
amounts and any required deductible and Coinsurance amounts under
this Health Care 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 the Claim Adminis-
trator for Covered Services that the Servicing Plan passes to the Claim
Administrator, 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 ren-
dered in those states, the Coinsurance amount will be calculated using
the state’s statutory method.

**Claim Administrator’s Separate Financial Arrangements with
Pharmacy Benefit Managers**

The Claim Administrator owns a significant portion of the equity of
Prime Therapeutics LLC and informs you that the Claim Administrator
has entered into one or more agreements with Prime Therapeutics LLC
or other entities (collectively referred to as “Pharmacy Benefit Manag-
ers”) to provide, on the Claim Administrator’s behalf, Claim Payments
and certain administrative services for your prescription drug benefits.
Pharmacy Benefit Managers have agreements with pharmaceutical
manufacturers to receive rebates for using their products. The Pharmacy
Benefit Manager may share a portion of those rebates with the Claim Ad-
ministrator. Neither the Employer nor you are entitled to receive any
portion of such rebates as they are figured into the pricing of the product.
Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). The Claim Administrator may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

   a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

   b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

   c. A Covered Person’s claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

   a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

   b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

   c. The use of an adjective such as Participating, Administrator 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.

d. 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 ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator’s records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator’s records. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, retiree benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and
records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

7. PHYSICAL EXAMINATION AND AUTOPSY

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

8. VALUE BASED DESIGN PROGRAMS

The Claim Administrator and your Employer has the right to offer medical management programs, a quality improvement programs and health behavior wellness, maintenance, or improvement program that allows for a reward, a contribution, a penalty, a differential in premiums or medical, prescription drug or equipment Copayments, Coinsurance or deductibles, or costs or a combination of these incentives or disincentives for participation in any such program offered or administered by the Claim Administrator or an entity chosen by the Claim Administrator to administer such program. In addition, discount programs for various health and wellness-related or insurance-related or other items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Contact your Employer for additional information regarding any value based programs offered by your Employer.

9. OVERPAYMENT

If your group’s benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error (“Overpayment”), your group’s plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your Group’s benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

- Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or
b. Any future benefit payment made to any person or entity under another blue Cross and Blue Shield administered ASO benefit program; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future benefit payment owed to one or more Participating or Non-Participating Providers.

Further, the Claim Administrator has the right to reduce your benefit plan’s or policy’s payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield’s plan or policy’s Overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield’s plan or policy.
REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider’s Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage (“ADP”) applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”)
ASO-1
Effective Date: January 1, 2018
www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and does not assume any financial risk or obligation with respect to claims.
Schedule A-2
(WI employees)
(Blue Cross Blue Shield of Illinois)
Your Health Care Benefit Program

Farm Credit Foundations
Retiree WISC Consumer Choice 1
201738

Administered by:

BlueCross BlueShield of Illinois
A message from

Farm Credit Foundations

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

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

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Retiree Benefits Department.

Sincerely,

Farm Credit Foundations
NOTICE

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

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

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

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

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

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.
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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 booklet.

THE UTILIZATION REVIEW PROGRAM

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

Lifetime Maximum for all Benefits

Unlimited

Individual Coverage Deductible**

$1,500 per benefit period

Family Coverage Deductible**

$3,000 per benefit period

Individual Coverage Out-of-Pocket Expense Limit**

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Provider</td>
<td>$3,000 per benefit period</td>
</tr>
<tr>
<td>Non-Participating Provider</td>
<td>$6,000 per benefit period</td>
</tr>
<tr>
<td>Non-Administrator Provider</td>
<td>No limit</td>
</tr>
</tbody>
</table>

Family Coverage Out-of-Pocket Expense Limit**

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Provider</td>
<td>$6,000 per benefit period</td>
</tr>
<tr>
<td>Non-Participating Provider</td>
<td>$12,000 per benefit period</td>
</tr>
<tr>
<td>Non-Administrator Provider</td>
<td>No limit</td>
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HOSPITAL BENEFITS

Payment level for Covered Services from a Participating Provider:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Payment Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>80% of the Eligible Charge</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% of the Eligible Charge</td>
</tr>
</tbody>
</table>

Payment level for Covered Services from a Non-Participating Provider:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Payment Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>60% of the Eligible Charge</td>
</tr>
<tr>
<td>Outpatient</td>
<td>60% of the Eligible Charge</td>
</tr>
</tbody>
</table>

Payment level for Covered Services from a Non-Administrator Provider

100% of the Non-Participating Hospital Benefit Payment Level
Hospital Emergency Care
— Payment level for 80% of the Eligible Charge
  Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider
— Payment level for 80% of the Eligible Charge
  Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider

BLUE DISTINCTION/
BLUE DISTINCTION PLUS

Transplants
— Blue Distinction Designated Center 100% of the Eligible Charge, no deductible
— Blue Distinction Plus Designated Center 100% of the Eligible Charge, no deductible
— Participating Provider 80% of the Eligible Charge
— Non-Participating Provider 60% of the Eligible Charge

PHYSICIAN BENEFITS
Payment level for Surgical/ Medical Covered Services
— **Participating Provider** 80% of the Maximum Allowance
— **Non-Participating Provider** 60% of the Maximum Allowance

Payment level for Emergency Accident Care 80% of the Maximum Allowance
Payment level for Emergency Medical Care 80% of the Maximum Allowance

OTHER COVERED SERVICES
Payment level 80% of the Eligible Charge or Maximum Allowance

HEARING BENEFITS
Hearing examination 80% of the Claim Charge
Hearing Aids Maximum $1,500 (every 36 month)

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

**Should the Federal Government adjust the Deductible for High Deductible Plans as defined by the Internal Revenue Service, the Deductible amount in this benefit booklet will be adjusted accordingly.
DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

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

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

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

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

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

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

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE.....means the amount that represents the billed charges from the majority of the ambulance providers in the Chicago metro area, as submitted to the Claim Administrator.

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

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

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

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

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

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

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

AVERAGING DISCOUNT PERCENTAGE ("ADP").....means a percentage discount determined by the Claim Administrator that will be applied to a Provider’s Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator’s reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”) In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator’s contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.
BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorder and is operating within the scope of such license.

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

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

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

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

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

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

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

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

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

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and
(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

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

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

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

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

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

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

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

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

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

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

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

CHIROPRACTOR.....means a duly licensed chiropractor and is operating within the scope of his or her license.

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

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

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

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

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

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

A “Non-Participating Clinical Laboratory” means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.
CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor operating within the scope of his or her license.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

A “Participating Clinical Social Worker” means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

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 Pri-
vate Duty Nursing Service. It also does not cover services for activities of
daily living (personal hygiene, cleaning, cooking, etc.).

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

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

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

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

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

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

CREDITABLE COVERAGE.....means coverage you had under any of the fol­
lowing:

(i) A group health plan.

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

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

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

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

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

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits
Program.
(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

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

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

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

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

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

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans and positron emission tomography (PET) scans.

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

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

A “Non-Administrator Dialysis Facility” means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.
DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

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

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other’s common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner’s life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner’s will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

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

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

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

(i) the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider’s Billed Charges, and (b) an amount determined by the Claim Administrator to be approximately 300% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider’s Billed Charges and (b) an amount determined by the Claim Administrator to be 300% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the Maximum Allowance cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 300% of the Provider’s Billed Charges (unless otherwise required by applicable law or arrangement with the Non-Participating Provider), provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to you.

In addition to the foregoing, the Eligible Charge will be subject in all respects to the Claim Administrator’s Claim Payment rules, edit and methodologies regardless of the Provider’s status as a Participating Provider or Non-Participating Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)
Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed charge for such Covered Services (unless otherwise required by applicable law or arrangement with the Non-Participating Provider).

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

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating Provider’s standard billed charge for such Covered Service (unless otherwise required by applicable law or arrangement with the Non-Participating Provider). (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an retiree of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

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

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

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

(ii) serious impairment to bodily functions; or

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

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

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

EMPLOYER.....means the company with which you are employed.

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

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

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

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

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

Although a Physician or Professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort. The Claim Administrator still may determine such services or supplies to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational.

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

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

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

A “Participating Home Infusion Therapy Provider” means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

A “Participating Hospice Care Program Provider” means a Hospice Care Program Provider that either: (i) has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

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

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

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

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

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

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

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

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

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

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

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

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

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

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

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

A “Participating Marriage and Family Therapist” means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with Non-Participating Providers):
(i) the Provider’s billed charges, or;

(ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 300% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

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

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

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

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

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

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).
MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

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

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

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

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

(i) Schizophrenia;

(ii) Paranoid and other psychotic disorders;

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

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

(v) Schizoaffective disorders (bipolar or depressive);

(vi) Pervasive developmental disorders;

(vii) Obsessive-compulsive disorders;

(viii) Depression in childhood and adolescence;

(ix) Panic disorder;

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

(xi) Anorexia nervosa and bulimia nervosa.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.
NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

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

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

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

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

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

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

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

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

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

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

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

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

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Sub-
stance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

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

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

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

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

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

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

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

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

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

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

PODIA TRIST.....means a duly licensed podiatrist operating within the scope of his or her license.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this benefit booklet.
PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

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

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

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

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

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

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

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

A “Non-Participating Provider” means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.
A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

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

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

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

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

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

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

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

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.
REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of his or her certification.

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

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

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

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

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

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

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.
A “Participating Retail Health Clinic” means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

ROUTINE PATIENT COSTS.....means the cost for all items and services consistent with the coverage provided under this benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

(i) The investigational item, device, or service, itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

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

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

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

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

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

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

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

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

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.
TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

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

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

TRANSPLANT LODGING ELIGIBLE EXPENSE.....means the amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

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

VIRTUAL PROVIDER.....means a licensed Provider who has a written agreement with the Claim Administrator to provide diagnosis and treatment of injuries and illnesses through either i) interactive audio communication (via telephone or other similar technology) or ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology) to you at the time services are rendered, operating within the scope of such license.

VIRTUAL VISIT.....means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the VIRTUAL VISITS provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.
The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of the following Covered Services before such services are rendered:

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

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

**PREADMISSION REVIEW**

- **Inpatient Hospital Preadmission Review**

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

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

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

- **Emergency Admission Review**

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

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

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

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

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

• Skilled Nursing Facility Preadmission Review

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

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

• Coordinated Home Care Program Preadmission Review

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

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

• Private Duty Nursing Service Review

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

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

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

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

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

LENGTH OF STAY/SERVICE REVIEW

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

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

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

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

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

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

Remember that the Claim Administrator’s Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

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

UTILIZATION REVIEW PROCEDURE

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

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

Upon receipt of the required information, the Claim Administrator:

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

APPEAL PROCEDURE

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

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

Medical Director  
Health Care Service Corporation  
P. O. Box A3957  
Chicago, Illinois 60601

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

**FAILURE TO NOTIFY**

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

**MEDICARE ELIGIBLE MEMBERS**

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.
CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

The Claim Administrator’s Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Use Disorder. 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 may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

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

In order to receive maximum benefits under this Health Care Plan, you must Preauthorize for your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit. Participating and Non-Participating Providers may call the Mental Health Unit Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Residential Treatment Center Preauthorization Review**

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

Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness or Substance Use Disorder is recommended by your physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Mental Health Unit. This call must be made at least one day prior to scheduling of the admission. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.
• **Emergency Mental Illness or Substance Use Disorder Admission Review**

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

   In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may call the Mental Health Unit Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

• **Partial Hospitalization Treatment Program Review**

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

   In order to receive maximum benefits under this Health Care Plan, you must notify the Mental Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Participating and Non-Participating Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

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

• **Length of Stay/Service Review**

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

   Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.
An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary 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.

MEDICALLY NECESSARY DETERMINATION

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

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

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

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.
MENTAL HEALTH UNIT PROCEDURE

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

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

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

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit 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 Behavioral Health Practitioner 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 Behavioral Health Practitioner 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 request a written appeal to be considered by the Mental Health Unit Physician for determination.
Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

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

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

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

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

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

FAILURE TO PREAUTHORIZE OR NOTIFY

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

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM (“IBMP”)

In addition to the benefits described in this benefit booklet, 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 the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.
MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.
THE PARTICIPATING PROVIDER OPTION

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

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

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

YOUR BENEFIT PERIOD

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

YOUR DEDUCTIBLE

If you have Individual Coverage, each benefit period you must satisfy a $1,500 benefit program deductible before receiving benefits. After you have Claims for Covered Services in a benefit period which exceed this deductible amount, your benefits will begin.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has satisfied the family deductible amount of $3,000, it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the benefit program deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family deductible amount has been satisfied.

The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.
HOSPITAL BENEFIT SECTION

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

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

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider’s charges. Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

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

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
   — a semi-private room
   — a private room
   — an intensive care unit

2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

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

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

Partial Hospitalization Treatment

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

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.
BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider
When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 80% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital’s rate for its most common type of room with two or more beds.

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.

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

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

Outpatient Hospital Covered Services
1. Surgery and any related Diagnostic Service received on the same day as the Surgery. In addition, benefits for Covered Services received for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care
8. Emergency Medical Care
9. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis

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

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider
Benefits will be provided at 80% 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.

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

Emergency Care
Benefits for Emergency Accident Care will be provided at 80% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Accident Care from either Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Accident Care will be subject to the Participating Provider program deductible.

Benefits for Emergency Medical Care will be provided at 80% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Medical Care from either Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Medical Care will be subject to the Participating Provider program deductible.

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

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

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

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

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

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

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

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

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

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

COVERED SERVICES

Surgery

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

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

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon’s office or Ambulatory Surgical Facility.
In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

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

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

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

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

- It is attributable to cerebral palsy, epilepsy or any other condition, other than a Mental Illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
- It manifested before the age of 22;
- It is likely to continue indefinitely; and
- It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.

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

3. Sterilization Procedures (even if they are elective).
4. Gender reassignment—benefits for Covered Services for gender reassignment Surgery, including related services and supplies, will be provided the same as for any other condition.

**Medical Care**

Benefits are available for Medical Care visits when:

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

**Consultations**

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

**Diabetes Self-Management Training and Education**

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will also be provided for education programs that allow you to maintain a hemoglobin A1c level within the range identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management, operating within the scope of his/her license. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

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

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

**Emergency Accident Care**

**Emergency Medical Care**

**Electroconvulsive Therapy**

**Allergy Injections and Allergy Testing**
Chemotherapy

Occupational Therapy

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

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.

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.

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.

Clinical Breast Examinations

Bone Mass Measurement and Osteoporosis

Experimental/Investigational Treatment

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

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

**Acupuncture**—Benefits will be provided for acupuncture when rendered by a licensed acupuncturist.

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

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

**Orthotic Devices**

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

**Outpatient Contraceptive Services**

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

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

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

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

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

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

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

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

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

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 80% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator’s benefit payment and the Provider’s charge to you.

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.
Emergency Care

Benefits for Emergency Accident Care will be provided at 80% 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 80% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

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

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

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

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

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

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

Participating Providers are:

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

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

Non-Participating Providers are:

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

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

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.
OTHER COVERED SERVICES

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

- The processing, transporting, storing, handling and administration of blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration.
- Medical and surgical dressings, supplies, casts and splints.
- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia. Benefits for wigs will be limited to a lifetime maximum of $500.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.

Benefits for ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility) will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance after you have met your program deductible.

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

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

**Participating Providers are:**

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

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

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

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

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.
SPECIAL CONDITIONS AND PAYMENTS

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

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ 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 booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

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

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

— Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs.

— If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available,
your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

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

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

Blue Distinction Centers of Treatment (BDCT)

Blue Distinction is a designation awarded by Blue Cross and Blue Shield companies to health care facilities that have demonstrated expertise in delivering quality health care. At the core of the program are Blue Distinction Centers for Specialty Care. Blue Distinction Centers are recognized for providing distinguished care in the areas of:

  • Transplants

The goal of Blue Distinction is to help you find specialty care while enabling and encouraging health care Providers to improve the overall quality and cost of care nationwide. Although your plan may require you to receive treatment at a Blue Distinction Center to get the highest level of benefits, you may still be covered at a non-Blue Distinction Center, but your out-of-pocket costs will usually be higher. Please refer to your Benefit Highlights section to see the payment levels for procedures performed at Blue Distinction Centers and procedures performed at other facilities. Blue Distinction benefit levels apply to facility benefits only. Travel and lodging benefits are the same as those outlined in the Human Organ Transplants section.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.
PREVENTIVE CARE SERVICES

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

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

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

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

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

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

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

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

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for the Copayment or Coinsurance for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment or Coinsurance for the office visit including the preventive health service.
Preventive Care Services for Adults (or others as specified):

1. Abdominal aortic aneurysm screening for men who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults over age 50
7. Depression screening
8. Type 2 diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
   - Hepatitis A
   - Hepatitis B
   - Herpes Zoster (Shingles)
   - Human papillomavirus
   - Influenza (Flu shot)
   - Measles, Mumps, Rubella
   - Meningococcal
   - Pneumococcal
   - Tetanus, Diphtheria, Pertussis
   - Varicella
12. Obesity screening and counseling
13. Sexually transmitted infections (STI) prevention
14. Tobacco use screening and cessation interventions for tobacco users
15. Syphilis screening for adults at higher risk
16. Physical Therapy to prevent falls in adults age 65 years and older who are at increased risk for falls
17. Hepatitis C virus (HCV) screening for adults at increased risk, and one time for everyone born 1945–1965
18. Hepatitis B virus screening for persons at high risk for infection
19. Counseling children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
20. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 and older

21. Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls

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

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

24. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history or CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking), and (c) a calculated 10-year CVD risk of 10% or greater

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

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

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

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

3. Breast cancer chemoprevention counseling for women at higher risk

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

5. Cervical cancer screening

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

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

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

9. Daily supplements for women who may become pregnant

10. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes

11. Gonorrhea screening for all women at higher risk

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

13. HIV screening and counseling for sexually active women and prenatal HIV testing
14. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
15. Osteoporosis screening for women over age 60, depending on risk factors
16. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
17. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
18. Sexually transmitted infections (STI) counseling for women
19. Syphilis screening for all pregnant women or other women at increased risk
20. Well-woman visits to obtain recommended preventive services
21. Breast cancer mammography screenings, including breast tomosynthesis and, if Medically Necessary, a screening MRI
22. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal
23. Aspirin use for pregnant women to prevent preeclampsia
24. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

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

1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Critical congenital heart defect screening for newborns
7. Major depression disorder (“MDD”) screening for adolescents
8. Development screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorder
10. Fluoride chemoprevention supplements for children without fluoride in their water source
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, weight and body mass index measurements
14. Hematocrit or hemoglobin screening
15. Hemoglobinopathies or sickle cell screening for all newborns
16. HIV screening for adolescents at higher risk
17. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
   - Hepatitis A
   - Hepatitis B
   - Human papillomavirus
   - Influenza (Flu shot)
   - Measles, Mumps, Rubella
   - Meningococcal
   - Pneumococcal
   - Tetanus, Diphtheria, Pertussis
   - Varicella
   - Haemophilus influenzae type b
   - Rotavirus
   - Inactivated Poliovirus
18. Lead screening for children at risk for exposure
19. Medical history for all children throughout development
20. Obesity screening and counseling
21. Oral health risk assessment for younger children up to ten years old
22. Phenylketonuria (PKU) screening for newborns
23. Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk
24. Tuberculin testing for children at higher risk of tuberculosis
25. Vision screening for all children
26. Autism screening
27. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
28. Newborn blood screening
29. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

The FDA-approved contraceptive drugs and devices currently covered under this benefit provision are listed on the Women’s Contraceptive Coverage List. This list is available on the Claim Administrator’s website at www.bcbsil.com and/or by contacting customer service at the toll-free number on your identification card. Benefits are not available under this benefit provision for
contraceptive drugs and devices not listed on the Women’s Contraceptive Coverage List. You may, however, have coverage under other sections of this benefit booklet, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The Women’s Contraceptive Coverage List and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

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

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

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

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

WELLNESS CARE

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

- Routine diagnostic medical procedures;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray.

Participating Provider

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

Non-Participating Provider

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

**SKILLED NURSING FACILITY CARE**

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

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 80% 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.

**AMBULATORY SURGICAL FACILITY**

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

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services rendered 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.

**SUBSTANCE USE DISORDER REHABILITATION TREATMENT**

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center. Substance Use Disorder Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.
DETOXIFICATION

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

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

BARIATRIC SURGERY

Benefits for Covered Services received for bariatric Surgery will be provided under the HOSPITAL BENEFIT and PHYSICIAN BENEFIT sections of this benefit booklet, the same as for any other condition.

MATERNITY SERVICE

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

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

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours). Such an earlier discharge may only be provided if there is coverage and avail-
ability of a post-discharge Physician office visit or an in-home visit to verify the condition of the infant in the first 48 hours after discharge.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis of infertility.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility or the inability to attain or maintain a viable pregnancy, or sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments.

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

MASTECTOMY-RELATED SERVICES

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

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

VIRTUAL VISITS

Benefits will be provided for Covered Services described in this benefit booklet for the diagnosis and treatment of non-emergency medical injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room office visit. Benefits for such Covered Services will only be provided if you receive them via consultation with a Virtual Provider who has a specific written agreement with the Claim Administrator to provide Virtual Visits to you at the time services are rendered. For more information about this benefit, you may visit the Claim Administrator’s website at www.bcbsil.com or call customer service at the number on the back of your identification card.

Benefits for Covered Services you receive through a Virtual Visit from a Participating Virtual Provider are subject to a Copayment of $44 per visit and then will be provided at 100% of the Maximum Allowance, after you have met your program deductible.

Benefits will not be provided for services you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with the Claim Administrator to provide Virtual Visits.

Note: Not all medical conditions can be appropriately treated through Virtual Visits. The Virtual Provider will identify any condition for which treatment by an in-person Provider is necessary.

PAYMENT PROVISIONS

Lifetime Maximum

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

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $3,000, any additional eligible Claims for Participating Providers (except for those charges specifically excluded below)
during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

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

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

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or Non-Administrator Provider
- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

If you have Family Coverage and your family’s out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $6,000 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 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 you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $6,000, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

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

- the 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

• Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

If you have Family Coverage and your family’s out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $12,000 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 will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

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

Your Hospital coverage also includes benefits for Hospice Care Program Service.

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

The following services are covered under the Hospice Care Program:
1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are not covered under the Hospice Care Program:
1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

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

Benefit Payment for Hospice Care Program Services

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

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

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

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

In addition to the Definitions of this benefit booklet, the following definitions are applicable to this Benefit Section:

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

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

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

Benefit Period

Your hearing care benefit period begins on the first date a Covered Service is received after your Coverage Date and continues for a period of 36 consecutive months thereafter. Later benefit periods will begin on the first date a Covered Service is received following the expiration of your prior benefit period.

Covered Services

Benefits will be provided under this Benefit Section for the following:

- Audiometric Examination
- Hearing Aid Evaluation
- Conformity Evaluation
- Hearing Aids

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

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.
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.

**Benefit Payment for Hearing Care**

Benefits for hearing care Covered Services, other than audiometric examinations, will be payable at 80% of the Claim Charge after you have met your program deductible.

Benefits for audiometric examinations will be payable at 80% of the Eligible Charge or 80% of the Maximum Allowance after you have met your program deductible.

Benefits for hearing care Covered Services other than audiometric examinations will be provided up to a maximum of $1,500 every 36 months.
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 booklet (see provisions entitled “Medicare Eligible Covered Persons” in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet 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 Health Care 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 Health Care Plan.

When you have a Claim, you must send the Claim Administrator 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.
EXCLUSIONS - WHAT IS NOT COVERED

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

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

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician’s office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient’s condition.

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

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

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other 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.
The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

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

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

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

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

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

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

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

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

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

— Custodial Care Service.

— Long Term Care Service.

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

— Inpatient Private Duty Nursing Service.

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

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

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

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

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

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

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

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

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

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

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

— Immunizations, unless otherwise specified in this benefit booklet.

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

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability or mental disability.

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

— Hypnotism.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

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

— Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet.

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

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

— Elective abortions.

— Reversals of sterilization.

— Services and supplies rendered or provided for the treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination and all forms of in-vitro fertilization unless otherwise stated in the Benefit Highlights.

— Naprapathic services.
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 Health Care 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 Health Care Plan if no other group coverages were involved. It is your obligation to notify the Claim Administrator 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 Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.

2. When a dependent child receives services, the birthdays of the child’s parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent’s birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this “birthday” type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
   — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
   — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to
notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

In order to prevent duplicate payment of benefits for a Claim, the Claim 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 Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.
HOW TO FILE A CLAIM AND APPEALS PROCEDURES

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your identification card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator’s records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Retiree Benefits Department or from the Claim Administrator’s office.

2. Attach copies of all bills to be considered for benefits. These bills must include the Provider’s name and address, the patient’s name, the diagnosis, the date of service and a description of the service and the Claim Charge.

3. Mail the completed Claim Form with attachments to:
   Blue Cross and Blue Shield of Illinois
   P. O. Box 805107
   Chicago, Illinois 60680-4112

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

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator’s office.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

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

If a Claim Is Denied or Not Paid in Full

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

a. The reasons for determination;

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

c. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary;

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

e. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or external review);

f. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

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

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

j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant’s medical circumstances, if the determination was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
In the case of a determination of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such Claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator’s offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday. Customer service hours and operations are subject to change without notice.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, IL 60680-4112
1-800-538-8833 Toll-free phone

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your identification card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INQUIRIES AND COMPLAINTS

An “Inquiry” is a general request for information regarding claims, benefits, or membership.

A “Complaint” is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

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

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

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

When you contact customer service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of
receipt by customer service. Sometimes the acknowledgement and the re¬
sponse will be combined. If the Claim Administrator needs more information,
you will be contacted. If a response to your Inquiry or Complaint will be
delayed due to the need for additional information, you will be contacted. If an
Inquiry or Complaint is not resolved to your satisfaction, you may appeal to
the Claim Administrator.

An appeal is an oral or written request for review of an Adverse Benefit De¬
termination (as defined below) or an adverse action by the Claim
Administrator, its employees or a Provider.

The following is the contact information for the Illinois Department of Insur¬
ance consumer assistance and ombudsman:

For Complaints and general Inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
Consumer_complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Timing of Required Notices and Extensions

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

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

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

c. Post-Service Claim is notification in a form acceptable to the Claim Ad¬
ministrator that a service has been rendered or furnished to you. This
notification must include full details of the service received, including
your name, age, sex, identification number, the name and address of the
Provider, an itemized statement of the service rendered or furnished, the
date of service, the diagnosis, the Claim charge, and any other informa¬
tion which the Claim Administrator may request in connection with
services rendered to you.
**Urgent Care Clinical Claims***

<table>
<thead>
<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>24 hours**</td>
</tr>
<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:</td>
<td>48 hours after receiving notice</td>
</tr>
</tbody>
</table>

*The Claim Administrator must notify you of the Claim determination (whether adverse or not):*

| if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than: | 72 hours                                      |
| after receiving the completed Claim (if the initial Claim is incomplete), within: | 48 hours                                      |

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

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

**Pre-Service Claims**

<table>
<thead>
<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your Claim is filed improperly, the Claim Administrator must notify you within:</td>
<td>5 days*</td>
</tr>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>15 days</td>
</tr>
<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:</td>
<td>45 days after receiving notice</td>
</tr>
</tbody>
</table>

*The Claim Administrator must notify you of the Claim determination (whether adverse or not):*

| if the initial Claim is complete, within: | 15 days**                                  |
| after receiving the completed Claim (if the initial Claim is incomplete), within: | 30 days                                      |
| If you require post-stabilization care after an Emergency within: | the time appropriate to the circumstance not to exceed one hour after the time of request |

*Notification may be oral unless the claimant requests written notification.*
This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

**Post-Service Claims**

<table>
<thead>
<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:</td>
<td>45 days after receiving notice</td>
</tr>
<tr>
<td><strong>The Claim Administrator must notify you of any adverse Claim determination:</strong></td>
<td></td>
</tr>
<tr>
<td>if the initial Claim is complete, within:</td>
<td>30 days*</td>
</tr>
<tr>
<td>after receiving the completed Claim (if the initial Claim is incomplete), within:</td>
<td>45 days</td>
</tr>
</tbody>
</table>

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

**Concurrent Care**

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

**CLAIM APPEAL PROCEDURES - DEFINITIONS**

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

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

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Claim Administrator will render a decision on the appeal within 24 hours after it receives the requested information, but not more than 72 hours from the appeal request.

Standard or Non-Urgent Appeals

The Claim Administrator will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

How to Appeal an Adverse Benefit Determination

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

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Under your health benefit plan, there is one level of internal appeal available to you. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your identification card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

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

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a Claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination.
In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, with to file a complaint or wish to take up your matter with the IDOI, you may use either address below:

IDOI Consumer Division
320 W. Washington St.
Springfield, Illinois 62767
1-217-782-4515

or

IDOI Consumer Division
122 S. Michigan Ave., 19th Floor
Chicago, Illinois 60603
1-312-814-2420

Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.

Send a written appeal request to:
The Claim Administrator
Claim Review Section
P.O. Box 2401
Chicago, Illinois 60690

To file an appeal or if you have questions, please call 800-538-8833 (TTY/TDD:711, send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members (BAM) at bcbsil.com

During the course of your internal appeal(s), the Claim Administrator will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by the Claim Administrator in connection with the appealed Claim, as well as any new or additional rationale for a determination at the internal ap-
peals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. The Claim Administrator may extend the time period described in this benefit booklet for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial determination of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.

Timing of Non-Urgent Appeal Determinations

Upon receipt of a non-urgent concurrent pre-service or post-service appeal, the Claim Administrator will notify the party filing the appeal within five business days of all the information needed to review the appeal.

The Claim Administrator will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 calendar days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 30 calendar days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you have already received the service.

If the appeal is related to administrative matters or Complaints, the Claim Administrator will render a decision of a pre-service or post-service appeal as soon as practical, but in no event more than 60 business days after receipt of all required information.

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and a statement describing determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

4. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final determination on internal and external appeal;

5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative;

6. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

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

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

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

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

12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;

13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review;

14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the
Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a Provider appeal.

If the Claim Administrator’s or your Employer’s decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the determination and issue a final decision. Your external review rights are described in the STANDARD EXTERNAL REVIEW section below.

You may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the Complaint. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO). The external review is at no charge to the member.

An “Adverse Benefit Determination” means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

A “Final Internal Adverse Benefit Determination” means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator’s internal review/appeal process.

1. Request for external review. Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt
of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:

   a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

   b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

   c. You have exhausted the Claim Administrator’s internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the EXHAUSTION section below for additional information and exhaustion of the internal appeal process; and

   d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor’s Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the determination of benefits.
The IRO must provide the following:

a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

b. Timely notification to you or your authorized representative, in writing, of the request’s eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator’s internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned
IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;
(2) The attending health care professional’s recommendation;
(3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
(4) The terms of your plan to ensure that the IRO’s decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
(6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
(7) The opinion of the IRO’s clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous determination);
(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan’s decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. Request for expedited external review. Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STAN-
DARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator’s internal claims and appeals process.

4. Notice of final external review decision. The Claim Administrator’s contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.
External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.
GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR’S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator’s contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider’s Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. 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 the Claim Administrator’s separate financial arrangements with Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital’s Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance...
amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

BlueCard® Program

Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, the Claim Administrator will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever you access Covered Services outside the Claim Administrator’s service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.
b. The provider has negotiated with the Host Blue a price of $80, even though the provider’s standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over – or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

**Negotiated (non-BlueCard Program) National Account Arrangements**

As an alternative to the BlueCard Program, your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A,
BlueCard Program) made available to the Claim Administrator by the Host Blue.

Non-Participating Healthcare Providers Outside The Claim Administrator’s Service Area

a. Liability Calculation

(1) In General

When Covered Services are provided outside of the Claim Administrator’s service area by non-participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Booklet for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, the Claim Administrator may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then the Claim Administrator may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area (and described in Section (1) above); or

2. The following:

   (i) For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or

   (ii) For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

Value-Based Programs Negotiated Arrangements

If the Claim Administrator enters into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, Blue Cross and Blue Shield of Illinois will follow the same procedures
for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

**Blue Cross Blue Shield Global Core**

If you are outside the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

**Inpatient Services**

In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact the Claim Administrator to obtain Preauthorization for non-emergency Inpatient services.**

**Outpatient Services**

Outpatient Services are available for Emergency Care, Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

**Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider’s itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from the Plan, the Blue Cross Blue Shield Global Core Service Center or online at
www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

**Servicing Plans**

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans (“Servicing Plans”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator’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 the Claim Administrator 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 Health Care 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 the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, 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.

**Claim Administrator’s Separate Financial Arrangements with Pharmacy Benefit Managers**

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as “Pharmacy Benefit Managers”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.
Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufactures to cover the administrative costs of processing late payments). The Claim Administrator may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS
   a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.
   b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.
   c. A Covered Person’s claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS
   a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.
   b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.
   c. The use of an adjective such as Participating, Administrator 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.

d. 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 ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator’s records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator’s records. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, retiree benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and
records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

7. PHYSICAL EXAMINATION AND AUTOPSY

The Claim Administrator, at its own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

8. VALUE BASED DESIGN PROGRAMS

The Claim Administrator and your Employer has the right to offer medical management programs, a quality improvement programs and health behavior wellness, maintenance, or improvement program that allows for a reward, a contribution, a penalty, a differential in premiums or medical, prescription drug or equipment Copayments, Coinsurance or deductibles, or costs or a combination of these incentives or disincentives for participation in any such program offered or administered by the Claim Administrator or an entity chosen by the Claim Administrator to administer such program. In addition, discount programs for various health and wellness-related or insurance-related or other items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Contact your Employer for additional information regarding any value based programs offered by your Employer.

9. OVERPAYMENT

If your group’s benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error (“Overpayment”), your group’s plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your Group’s benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or
b. Any future benefit payment made to any person or entity under another blue Cross and Blue Shield administered ASO benefit program; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future benefit payment owed to one or more Participating or Non-Participating Providers.

Further, the Claim Administrator has the right to reduce your benefit plan’s or policy’s payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield’s plan or policy’s Overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield’s plan or policy.
REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider’s Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage (“ADP”) applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”)
Administered by:

BlueCross BlueShield of Illinois


ASO-1

Effective Date: January 1, 2018

www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and does not assume any financial risk or obligation with respect to claims.
BENEFIT SCHEDULE B

Farm Credit Foundations
Consumer Choice Option 2
(Group No. 201716 and 201739(WI))
Schedule B-1

(Everyone except WI employees)

(Blue Cross Blue Shield of Illinois)
A message from

Farm Credit Foundations

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Retiree Benefits Department.

Sincerely,

Farm Credit Foundations
NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.
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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 booklet.

THE UTILIZATION REVIEW PROGRAM

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet.

Lifetime Maximum for all Benefits Unlimited

Individual Coverage Deductible** $3,450 per benefit period

Family Coverage Deductible** $6,900 per benefit period

Individual Coverage Out-of-Pocket Expense Limit**

— Participating Provider $3,450 per benefit period
— Non-Participating Provider $6,900 per benefit period
— Non-Administrator Provider No limit

Family Coverage Out-of-Pocket Expense Limit**

— Participating Provider $6,900 per benefit period
— Non-Participating Provider $13,800 per benefit period
— Non-Administrator Provider No limit

HOSPITAL BENEFITS

Payment level for Covered Services from a Participating Provider:

— Inpatient Covered Services 100% of the Eligible Charge
— Outpatient Covered Services 100% of the Eligible Charge

Payment level for Covered Services from a Non-Participating Provider:

— Inpatient Covered Services 60% of the Eligible Charge
— Outpatient Covered Services 60% of the Eligible Charge

Payment level for Covered Services from a Non-Administrator Provider 100% of the Non-Participating Hospital Benefit Payment Level
Hospital Emergency Care
— Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider 100% of the Eligible Charge
— Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider 100% of the Eligible Charge

BLUE DISTINCTION/
BLUE DISTINCTION PLUS

Transplants
— Blue Distinction Designated Center 100% of the Eligible Charge, no deductible
— Blue Distinction Plus Designated Center 100% of the Eligible Charge, no deductible
— Participating Provider 100% of the Eligible Charge
— Non-Participating Provider 60% 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 100% of the Maximum Allowance
Payment level for Emergency Medical Care 100% of the Maximum Allowance

OTHER COVERED SERVICES
Payment level 100% of the Eligible Charge or Maximum Allowance
HEARING BENEFITS

- Hearing examination: 100% of the Claim Charge
- Hearing Aids Maximum: $1,500 (every 36 months)

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

**Should the Federal Government adjust the Deductible for High Deductible Plans as defined by the Internal Revenue Service, the Deductible amount in this benefit booklet will be adjusted accordingly.**
DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ACUTE TREATMENT SERVICES.....means a 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist operating within the scope of his or her certification.

AMBULANCE TRANSPORTATION.....means local transportation in specially equipped certified ground and air ambulance options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this health care plan.

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE.....means the amount that represents the billed charges from the majority of the ambulance providers in the Chicago metro area, as submitted to the Claim Administrator.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an
ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An “Administrator Ambulatory Surgical Facility” means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Ambulatory Surgical Facility” means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

(ii) A clinical trial conducted under an FDA experimental/investigational new drug application, or

(iii) A drug that is exempt from the requirement of an FDA experimental/investigational new drug application.

AVERAGE DISCOUNT PERCENTAGE (“ADP”).....means a percentage discount determined by the Claim Administrator that will be applied to a Provider’s Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator’s reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”) In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator’s contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.
BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorder and is operating within the scope of such license.

BILLED CHARGES.....means the total gross amounts billed by Providers to the Claim Administrator on a Claim, which constitutes the usual retail price that the Provider utilizes to bill patients or any other party that may be responsible for payment of the services rendered without regard to any payor, discount or reimbursement arrangement that may be applicable to any particular patient. This list of retail prices is also sometimes described in the health care industry as a “chargemaster.”

CARE COORDINATION.....means organized, information-driven patient care activities intended to facilitate the appropriate responses to participant’s health care needs cross the continuum of care.

CARE COORDINATION FEE.....means a fixed amount paid by a Blue Cross and/or Blue Shield plan to Providers.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and
(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A “Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse and is operating within the scope of such license; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who does not have a written agreement...
with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceautical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor and is operating within the scope of his or her license.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider’s charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A “Participating Clinical Laboratory” means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Laboratory” means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.
CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor operating within the scope of his or her license.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Professional Counselor” means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker operating within the scope of his or her license.

A “Participating Clinical Social Worker” means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Social Worker” means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL STABILIZATION SERVICES.....means a 24-hour treatment, usually following acute treatment services for Substance Use Disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

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 Pri-
private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An “Administrator Coordinated Home Care Program” means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A “Non-Administrator Coordinated Home Care Program” means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

(i) A group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

(iv) Medicaid (Title XIX of the Social Security Act).

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.
(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

(x) A health plan under Section 5(e) of the Peace Corps Act.

(xi) State Children’s Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

DEDUCTIBLE.....means the amount of expense that you must incur in Covered Services before benefits are provided.

DENTIST.....means a duly licensed dentist operating within the scope of his or her license.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans and positron emission tomography (PET) scans.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services, when operating within the scope of such license.

An “Administrator Dialysis Facility” means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Dialysis Facility” means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.
DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person of the same or opposite sex which meets the following criteria:

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other’s common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner’s life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner’s will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider, when operating within the scope of such license.

A “Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, such Provider’s Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, the following amount:

(i) the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider’s Billed Charges, and (b) an amount determined by the Claim Administrator to be approximately 300% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider’s Billed Charges and (b) an amount determined by the Claim Administrator to be 300% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the Maximum Allowance cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 300% of the Provider’s Billed Charges (unless otherwise required by applicable law or arrangement with the Non-Participating Provider), provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to you.

In addition to the foregoing, the Eligible Charge will be subject in all respects to the Claim Administrator’s Claim Payment rules, edit and methodologies regardless of the Provider’s status as a Participating Provider or Non-Participating Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)
Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed charge for such Covered Services (unless otherwise required by applicable law or arrangement with the Non-Participating Provider).

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating Provider’s standard billed charge for such Covered Service (unless otherwise required by applicable law or arrangement with the Non-Participating Provider). (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an retiree of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowl-
edge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorders condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage under your Employer’s health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL or EXPERIMENTAL/INVESTIGATIONAL SERVICES AND SUPPLIES.....means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment for the condition being treated or, if any of such items required federal or other governmental agency approval, such approval was not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. As used herein, medical treatment includes medical, surgical, or dental treatment.

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
• the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-fixed programs in making its determination.

Although a Physician or Professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort. The Claim Administrator still may determine such services or supplies to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational.

Approval by a government or regulatory agency will be taken into consideration in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider, when operating within the scope of such license.

A “Participating Home Infusion Therapy Provider” means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Home Infusion Therapy Provider” means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service, when operating within the scope of such license.

A “Participating Hospice Care Program Provider” means a Hospice Care Program Provider that either: (i) has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

A “Non-Participating Hospice Care Program Provider” means a Hospice Care Program Provider that either: (i) does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice
Care Program Provider which has not been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

An “Administrator Hospital” means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Hospital” means a Hospital that does not meet the definition of an Administrator Hospital.

A “Participating Hospital” means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A “Non-Participating Hospital” means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INFERTILITY.....means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy.

INFUSION THERAPY.....means the administration of medication through a needle or catheter. It is prescribed when a patient’s condition is so severe that it cannot be treated effectively by oral medications. Typically, “Infusion Therapy” means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.
INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

LIFE-THREATENING DISEASE OR CONDITION.....means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST (“LMFT”).....means a duly licensed marriage and family therapist operating within the scope of his or her license.

A “Participating Marriage and Family Therapist” means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Marriage and Family Therapist” means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance
will be the lesser of (unless otherwise required by applicable law or arrange-
ment with Non-Participating Providers):

(i) the Provider’s billed charges, or;

(ii) the Claim Administrator non-contracting Maximum Allowance. Ex-
cept as otherwise provided in this section, the non-contracting 
Maximum Allowance is developed from base Medicare reimbur-
sements and represents approximately 300% of the base Medicare 
reimbursement rate and will exclude any Medicare adjustment(s) 
which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Al-
lowance for Coordinated Home Care Program Covered Services will be 50% 
of the Non-Participating Professional Provider’s standard billed charge for 
such Covered Services.

The base Medicare reimbursement rate described above will exclude any 
Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or 
is unable to be determined from the information submitted on the Claim, the 
Maximum Allowance for Non-Participating Professional Providers will be 100% of the Claim Administrator’s rate for such Covered Service according to 
its current Schedule of Maximum Allowance. If there is no rate according to 
the Schedule of Maximum Allowance, then the Maximum Allowance will be 
25% of Billed Charges.

The Claim Administrator will utilize the same Claim processing rules and/or 
edits that it utilizes in processing Participating Professional Provider Claims 
for processing Claims submitted by Non-Participating Professional Providers 
which may also alter the Maximum Allowance for a particular service. In the 
event the Claim Administrator does not have any Claim edits or rules, the 
Claim Administrator may utilize the Medicare claim rules or edits that are 
used by Medicare in processing the Claims. The Maximum Allowance will 
not include any additional payments that may be permitted under the Medi-
care laws or regulations which are not directly attributable to a specific Claim, 
including, but not limited to, disproportionate share payments and graduate 
medical education payments.

Any change to the Medicare reimbursement amount will be implemented by 
the Claim Administrator within 145 days after the effective date that such 
change is implemented by the Centers for Medicaid and Medicare Services, or 
its successor.

MEDICAL CARE.....means the ordinary and usual professional services ren-
dered by a Physician or other specified Provider during a professional visit for 
treatment of an illness or injury.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS 
BENEFIT BOOKLET.
MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits including Preauthorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions for the treatment of Mental Illness and Substance Use Disorder.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

“Serious Mental Illness”.....means the following mental disorders as classified in the current Diagnostic and Statistical Manual published by the American Psychiatric Association:

(i) Schizophrenia;
(ii) Paranoid and other psychotic disorders;
(iii) Bipolar disorders (hypomaniac, manic, depressive and mixed);
(iv) Major depressive disorders (single episode or recurrent);
(v) Schizoaffective disorders (bipolar or depressive);
(vi) Pervasive developmental disorders;
(vii) Obsessive-compulsive disorders;
(viii) Depression in childhood and adolescence;
(ix) Panic disorder;
(x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
(xi) Anorexia nervosa and bulimia nervosa.
NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist operating within the scope of his or her license.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist operating within the scope of his or her license.

A “Participating Optometrist” means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider operating within the scope of his or her license.

A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Orthotic Provider” means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.
PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider’s office, and where Legend Drugs and devices are dispensed under Prescriptions to the general public by a pharmacist licensed to dispense such drugs and devices under laws of the state in which he/she practices.

PHYSICAL THERAPIST.....means a duly licensed physical therapist operating within the scope of his or her license.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches operating within the scope of his or her license.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of his or her license.

PODIATRIST.....means a duly licensed podiatrist operating within the scope of his or her license.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION RE-
VIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this benefit booklet.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider operating within the scope of his or her license.

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you, and operating within the scope of such license.

An “Administrator Provider” means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Provider” means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A “Participating Provider” means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A “Non-Participating Provider” means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.
A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

A “Participating Prescription Drug Provider” means a Preferred or Non-Preferred Pharmacy, including but not limited to, an independent retail Pharmacy, chain or retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

A “Non-Participating Prescription Drug Provider” means a Pharmacy, including but not limited to, an independent retail Pharmacy, chain or retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which (i) has not entered into a written agreement with the Claim Administrator or (ii) has not entered into a written with any entity chosen by the Claim Administrator to administer its prescription drug program, for such Pharmacy to provide pharmaceutical services at the time Covered Services to participants in the benefit program at the time Covered Services are rendered.

PROVIDER INCENTIVE.....means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider’s compliance with agreed upon procedural and/or outcome measures for a particular population of participants.

PSYCHOLOGIST.....means a Registered Clinical Psychologist operating within the scope of such license.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois “Psychologists Registration Act” or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.
REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of his or her certification.

A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Registered Surgical Assistant” means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESCISSION.....means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums. A “Rescission” does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders. Requirements: the Claim Administrator requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

RESPITE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.
A “Participating Retail Health Clinic” means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Retail Health Clinic” means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ROUTINE PATIENT COSTS.....means the cost for all items and services consistent with the coverage provided under this benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

(i) The investigational item, device, or service, itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services, and operating within the scope of such license.

An “Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An “Uncertified Skilled Nursing Facility” means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.
SPEECH THERAPIST.....means a duly licensed speech therapist operating within the scope of his or her license.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE USE DISORDER.....means chemical dependency and/or the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disability or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such license. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An “Administrator Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility that does not meet the definition of an Administrator Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.
TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOBACCO USER.....means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your identification card or visit our Website at www.bcbsil.com.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

TRANSPLANT LODGING ELIGIBLE EXPENSE.....means the amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

VALUE BASED PROGRAM.....means an outcome based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

VIRTUAL PROVIDER.....means a licensed Provider who has a written agreement with the Claim Administrator to provide diagnosis and treatment of injuries and illnesses through either i) interactive audio communication (via telephone or other similar technology) or ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology) to you at the time services are rendered, operating within the scope of such license.

VIRTUAL VISIT.....means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the VIRTUAL VISITS provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.
UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of the following Covered Services before such services are rendered:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

PREADMISSION REVIEW

- Inpatient Hospital Preadmission Review

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must call the Claim Administrator’s medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- Emergency Admission Review

  Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In the event of an emergency admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred.
• **Pregnancy/Maternity Admission Review**

Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

In the event of a maternity admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred.

Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

• **Skilled Nursing Facility Preadmission Review**

Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must call the Claim Administrator’s medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

• **Coordinated Home Care Program Preadmission Review**

Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must call the Claim Administrator’s medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

• **Private Duty Nursing Service Review**

Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever Private Duty Nursing Service is recommended by your Physician, you must call the Claim Administrator’s medical pre-notification number. This call must be made at least one business day prior to receiving services.
CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS—WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator’s determination of Medically Necessary care is limited to merely
whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator’s Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You
should call the Claim Administrator’s customer service number on your identification card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.
CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

The Claim Administrator’s Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Use Disorder. 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 may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below.

PREAUTHORIZATION REVIEW

- Inpatient Hospital Preauthorization Review

  Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan, you must Preauthorize for your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit. Participating and Non-Participating Providers may call the Mental Health Unit Preauthorize for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- Residential Treatment Center Preauthorization Review

  Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

  Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness or Substance Use Disorder is recommended by your physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Mental Health Unit. This call must be made at least one day prior to scheduling of the admission. Participating and Non-Participating Providers may Preauthorize for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.
• **Emergency Mental Illness or Substance Use Disorder Admission Review**

Emergency Mental Illness or Substance Use Disorder Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may call the Mental Health Unit Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

• **Partial Hospitalization Treatment Program Review**

Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must notify the Mental Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Participating and Non-Participating Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

• **Length of Stay/Service Review**

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.
An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary 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.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission or other health care service or supply does not meet the criteria for Medically Necessary care, some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admission, the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, “EXCLUSIONS—WHAT IS NOT COVERED.”

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Mental Health Unit’s determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient Hospital admission or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.
MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit 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 Behavioral Health Practitioner 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 Behavioral Health Practitioner 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 Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO PREAUTHORIZE OR NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM (“IBMP”)

In addition to the benefits described in this benefit booklet, 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 the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.
MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.
THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator’s “Participating Provider Option” for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois Website at www.bcbsil.com for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms “Benefit Period” and “Deductible” as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

If you have Individual Coverage, each benefit period you must satisfy a $3,450 benefit program deductible before receiving benefits. After you have Claims for Covered Services in a benefit period which exceed this deductible amount, your benefits will begin.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has satisfied the family deductible amount of $6,900, it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the benefit program deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family deductible amount has been satisfied.

The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.
HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider’s charges.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
   — a semi-private room
   — a private room
   — an intensive care unit

2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.
BENEFIT PAYMENT FOR INPATIENT
HOSPITAL COVERED SERVICES

Participating Provider
When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 100% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital’s rate for its most common type of room with two or more beds.

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.

Non-Administrator Provider
When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received from a Non-Participating Provider.

OUTPATIENT HOSPITAL CARE
The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services
1. Surgery and any related Diagnostic Service received on the same day as the Surgery. In addition, benefits for Covered Services received for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care
8. Emergency Medical Care
9. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis

10. Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

**BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES**

**Participating Provider**

Benefits will be provided at 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.

**Non-Administrator Provider**

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.

**Emergency Care**

Benefits for Emergency Accident Care will be provided at 100% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Accident Care will be subject to the Participating Provider program deductible.

Benefits for Emergency Medical Care will be provided at 100% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Medical Care will be subject to the Participating Provider program deductible.

However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually
transmitted disease or infection, will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Eligible Charge for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or

2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or

3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.
PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon’s office or Ambulatory Surgical Facility.
In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon’s office, Hospital or Ambulatory Surgical Facility if you are under age 19 and have been diagnosed with an autism spectrum disorder or a developmental disability.

For purposes of this provision only, the following definitions shall apply:

Autism spectrum disorder means.....a pervasive developmental disorder described by the American Psychiatric Association or the World Health Organization diagnostic manuals as an autistic disorder, atypical autism, Asperger Syndrome, Rett Syndrome, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified; or a special education classification for autism or other disabilities related to autism.

Developmental disability means.....a disability that is attributable to an intellectual disability or a related condition, if the related condition meets all of the following conditions:

- It is attributable to cerebral palsy, epilepsy or any other condition, other than a Mental Illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
- It manifested before the age of 22;
- It is likely to continue indefinitely; and
- It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.

3. Sterilization Procedures (even if they are elective).
4. Gender reassignment—benefits for Covered Services for gender reassignment Surgery, including related services and supplies, will be provided the same as for any other condition.

**Medical Care**

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Use Disorder Treatment Facility or a Residential Treatment Center or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician’s office or your Physician comes to your home.

**Consultations**

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician’s advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

**Diabetes Self-Management Training and Education**

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will also be provided for education programs that allow you to maintain a hemoglobin A1c level within the range identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management, operating within the scope of his/her license. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

**Diagnostic Service**—Benefits will be provided for those services related to covered Surgery or Medical Care.

**Emergency Accident Care**

**Emergency Medical Care**

**Electroconvulsive Therapy**

**Allergy Injections and Allergy Testing**
Chemotherapy

Occupational Therapy
Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

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.

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.

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.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Experimental/Investigational Treatment—Benefits will be provided for routine patient care in conjunction with experimental/investigational treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with an Approved Clinical Trial program. You and/or your Physician are encouraged
to call customer service at the toll-free number on your identification card in advance to obtain information about whether a particular clinical trial is qualified.

**Approved Clinical Trials**—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

**Acupuncture**—Benefits will be provided for acupuncture when rendered by a licensed acupuncturist.

**Durable Medical Equipment**—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

**Amino Acid-Based Elemental Formulas**—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

**Orthotic Devices**

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary.

**Outpatient Contraceptive Services**

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.
**Prosthetic Appliances**

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or

2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient’s condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

**Routine Pediatric Hearing Examination**—Benefits will be provided for routine pediatric hearing examinations.

**Pulmonary Rehabilitation Therapy**—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

**BENEFIT PAYMENT FOR PHYSICIAN SERVICES**

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

**Participating Provider**

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 100% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator’s benefit payment and the Provider’s charge to you.

**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.
Emergency Care

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.

However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Maximum Allowance for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or

2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or

3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
• Durable Medical Equipment Providers
• Home Infusion Therapy Providers
• Marriage and Family Therapists
• Occupational Therapists
• Optometrists
• Orthotic Providers
• Physical Therapists
• Prosthetic Providers
• Registered Surgical Assistants
• Retail Health Clinics
• Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator’s benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

• Physicians
• Podiatrists
• Psychologists
• Dentists
• Certified Nurse-Midwives
• Certified Nurse Practitioners
• Certified Clinical Nurse Specialists
• Certified Registered Nurse Anesthetists
• Chiropractors
• Clinical Social Workers
• Clinical Professional Counselors
• Clinical Laboratories
• Durable Medical Equipment Providers
• Home Infusion Therapy Providers
• Marriage and Family Therapists
• Occupational Therapists
• Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator’s benefit payment and such Provider’s charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.
OTHER COVERED SERVICES

This section of your benefit booklet describes “Other Covered Services” and the benefits that will be provided for them.

- The processing, transporting, storing, handling and administration of blood and blood components.

- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.

- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.

- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.

- Oxygen and its administration.

- Medical and surgical dressings, supplies, casts and splints.

- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia. Benefits for wigs will be limited to a lifetime maximum of $500.

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.

Benefits for ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility) will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance after you have met your program deductible.

Notwithstanding anything else described herein, Providers of ambulance services will be paid based on the amount that represents the billed charges from the majority of the ambulance Providers in the Chicago Metro area as submitted to the Claim Administrator. Benefits for Ambulance Transportation will be paid at the highest level available under this...
benefit program. However, you will be responsible for any charges in excess of this amount.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

**Participating Providers are:**

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator’s benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.
Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator’s benefit payment and such Provider’s charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.
SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ 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 booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

— the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

— Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs.

— If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available,
your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

— Benefits for transportation and lodging are limited to a combined lifetime maximum of $10,000. The maximum amount that will be provided for lodging is $50 per person per day.

— In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:
  
  • Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
  
  • Travel time and related expenses required by a Provider.
  
  • Drugs which do not have approval of the Food and Drug Administration.
  
  • Storage fees.
  
  • Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
  
  • Meals.

**Blue Distinction Centers of Treatment (BDCT)**

Blue Distinction is a designation awarded by Blue Cross and Blue Shield companies to health care facilities that have demonstrated expertise in delivering quality health care. At the core of the program are Blue Distinction Centers for Specialty Care. Blue Distinction Centers are recognized for providing distinguished care in the areas of:

- Transplants

The goal of Blue Distinction is to help you find specialty care while enabling and encouraging health care Providers to improve the overall quality and cost of care nationwide. Although your plan may require you to receive treatment at a Blue Distinction Center to get the highest level of benefits, you may still be covered at a non-Blue Distinction Center, but your out-of-pocket costs will usually be higher. Please refer to your Benefit Highlights section to see the payment levels for procedures performed at Blue Distinction Centers and procedures performed at other facilities. Blue Distinction benefit levels apply to facility benefits only. Travel and lodging benefits are the same as those outlined in the Human Organ Transplants section.

**CARDIAC REHABILITATION SERVICES**

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.
PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided for in this benefit booklet, (and notwithstanding anything in your benefit booklet to the contrary), the following preventive care services will be considered Covered Services and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service:

1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);

2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;

3. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and

4. with respect to women, such additional preventive care and screenings, not described in item 1. above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this preventive care services benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November, 2009).

The preventive care services described in items 1. through 4. above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Claim Administrator’s website at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, the Claim Administrator may use reasonable medical management techniques, including but not limited to, those related to setting and medical appropriateness to determine coverage.

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for the Copayment or Coinsurance for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment or Coinsurance for the office visit including the preventive health service.
Preventive Care Services for Adults (or others as specified):

1. Abdominal aortic aneurysm screening for men who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults over age 50
7. Depression screening
8. Type 2 diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
   - Hepatitis A
   - Hepatitis B
   - Herpes Zoster (Shingles)
   - Human papillomavirus
   - Influenza (Flu shot)
   - Measles, Mumps, Rubella
   - Meningococcal
   - Pneumococcal
   - Tetanus, Diphtheria, Pertussis
   - Varicella
12. Obesity screening and counseling
13. Sexually transmitted infections (STI) prevention
14. Tobacco use screening and cessation interventions for tobacco users
15. Syphilis screening for adults at higher risk
16. Physical Therapy to prevent falls in adults age 65 years and older who are at increased risk for falls
17. Hepatitis C virus (HCV) screening for adults at increased risk, and one time for everyone born 1945-1965
18. Hepatitis B virus screening for persons at high risk for infection
19. Counseling children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
20. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 and older
21. Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
22. Screening for high blood pressure in adults age 18 years or older
23. Screening for abnormal blood glucose and type II diabetes mellitus as part of cardiovascular risk assessment in adults who are overweight or obese.
24. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history or CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking), and (c) a calculated 10-year CVD risk of 10% or greater
25. Tuberculin testing for adults 18 years or older who are at risk of tuberculosis.

Preventive Care Services for Women (including pregnant women or others as specified):

1. Bacteriuria urinary tract screening or other infection screening for pregnant women
2. BRCA counseling about genetic testing for women at higher risk
3. Breast cancer chemoprevention counseling for women at higher risk
4. Breastfeeding comprehensive lactation support and counseling from trained providers, as well as, access to breastfeeding supplies for pregnant and nursing women. Electric breast pumps are limited to two per benefit period.
5. Cervical cancer screening
6. Chlamydia infection screening for younger women and women at higher risk
7. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
8. Domestic and interpersonal violence screening and counseling for all women
9. Daily supplements for women who may become pregnant
10. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
11. Gonorrhea screening for all women at higher risk
12. Hepatitis B screening for pregnant women at their first prenatal visit
13. HIV screening and counseling for sexually active women and prenatal HIV testing
14. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older

15. Osteoporosis screening for women over age 60, depending on risk factors

16. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk

17. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users

18. Sexually transmitted infections (STI) counseling for women

19. Syphilis screening for all pregnant women or other women at increased risk

20. Well-woman visits to obtain recommended preventive services

21. Breast cancer mammography screenings, including breast tomosynthesis and, if Medically Necessary, a screening MRI

22. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal

23. Aspirin use for pregnant women to prevent preeclampsia

24. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

**Preventive Care Services for Children (or others as specified):**

1. Alcohol and drug use assessment for adolescents

2. Behavioral assessments for children of all ages

3. Blood pressure screenings for children of all ages

4. Cervical dysplasia screening for sexually active females

5. Congenital hypothyroidism screening for newborns

6. Critical congenital heart defect screening for newborns

7. Major depression disorder (“MDD”) screening for adolescents

8. Development screening for children under age 3, and surveillance throughout childhood

9. Dyslipidemia screening for children at higher risk of lipid disorder

10. Fluoride chemoprevention supplements for children without fluoride in their water source

11. Gonorrhea preventive medication for the eyes of all newborns

12. Hearing screening for all newborns

13. Height, weight and body mass index measurements

14. Hematocrit or hemoglobin screening
15. Hemoglobinopathies or sickle cell screening for all newborns
16. HIV screening for adolescents at higher risk
17. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
   - Hepatitis A
   - Hepatitis B
   - Human papillomavirus
   - Influenza (Flu shot)
   - Measles, Mumps, Rubella
   - Meningococcal
   - Pneumococcal
   - Tetanus, Diphtheria, Pertussis
   - Varicella
   - Haemophilus influenzae type b
   - Rotavirus
   - Inactivated Poliovirus
18. Lead screening for children at risk for exposure
19. Medical history for all children throughout development
20. Obesity screening and counseling
21. Oral health risk assessment for younger children up to ten years old
22. Phenylketonuria (PKU) screening for newborns
23. Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk
24. Tuberculin testing for children at higher risk of tuberculosis
25. Vision screening for all children
26. Autism screening
27. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
28. Newborn blood screening
29. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

The FDA-approved contraceptive drugs and devices currently covered under this benefit provision are listed on the Women’s Contraceptive Coverage List. This list is available on the Claim Administrator’s website at www.bcbsil.com and/or by contacting customer service at the toll-free number on your identification card. Benefits are not available under this benefit provision for
contraceptive drugs and devices not listed on the Women’s Contraceptive Coverage List. You may, however, have coverage under other sections of this benefit booklet, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The Women’s Contraceptive Coverage List and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

Routine pediatric care, women’s preventive care (such as contraceptives) and/or Outpatient periodic health examinations Covered Services not included above will be subject to the deductible, Coinsurance, Copayments and/or benefit maximums previously described in your benefit booklet, if applicable.

Preventive care services received from a Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other routine Covered Services not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximums.

Benefits for vaccinations that are considered preventive care services will not be subject to any deductible, Coinsurance, Copayments and/or benefit maximum when such services are received from a Participating Provider or Participating Pharmacy.

Vaccinations that are received from a Non-Participating Provider, or a Non- Administrator Provider facility, or a Non-Participating Pharmacy or other vaccinations that are not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximum.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

- Routine diagnostic medical procedures;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray.

Participating Provider

When you receive Covered Services for wellness care from a Participating Provider, benefits for wellness care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Non-Participating Provider

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 100% of the Eligible Charge or
100% of the Maximum Allowance and will not be subject to the program deductible.

**SKILLED NURSING FACILITY CARE**

The following are Covered Services when you receive them in a Skilled Nursing Facility:

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.

**AMBULATORY SURGICAL FACILITY**

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 100% of the Eligible Charge. Benefits for services rendered 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.

**SUBSTANCE USE DISORDER REHABILITATION TREATMENT**

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center. Substance Use Disorder Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.
DETOXIFICATION
Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this benefit booklet, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES
Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

BARIATRIC SURGERY
Benefits for Covered Services received for bariatric Surgery will be provided under the HOSPITAL BENEFIT and PHYSICIAN BENEFIT sections of this benefit booklet, the same as for any other condition.

MATERNITY SERVICE
Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours). Such an earlier discharge may only be provided if there is coverage and avail-
ability of a post-discharge Physician office visit or an in-home visit to verify the condition of the infant in the first 48 hours after discharge.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis of infertility.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility or the inability to attain or maintain a viable pregnancy, or sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this benefit booklet are available for the appliances, diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge;
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; and
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered Cosmetic Surgery.

VIRTUAL VISITS

Benefits will be provided for Covered Services described in this benefit booklet for the diagnosis and treatment of non-emergency medical injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room office visit. Benefits for such Covered Services will only be provided if you receive them via consultation with a Virtual Provider who has a specific written agreement with the Claim Administrator to provide Virtual Visits to you at the time services are rendered. For more information about this benefit, you may visit the Claim Administrator’s website at www.bcbsil.com or call customer service at the number on the back of your identification card.

Benefits for Covered Services you receive through a Virtual Visit from a Participating Virtual Provider are subject to a Copayment of $44 per visit and then will be provided at 100% of the Maximum Allowance, after you have met your program deductible.

Benefits will not be provided for services you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with the Claim Administrator to provide Virtual Visits.

Note: Not all medical conditions can be appropriately treated through Virtual Visits. The Virtual Provider will identify any condition for which treatment by an in-person Provider is necessary.

PAYMENT PROVISIONS

Lifetime Maximum

Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $3,450, any additional eligible Claims for Participating Providers (except for those charges specifically excluded below)
during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for Covered Services for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or Non-Administrator Provider
- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

If you have Family Coverage and your family’s out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $6,900 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 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 you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $6,900, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the 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
• theCoinsurance 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

• Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

If you have Family Coverage and your family’s out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $13,800 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 will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program, Residential Treatment Center or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.
HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are not covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.
HEARING CARE PROGRAM

Your coverage includes benefits for hearing care when you receive such care from a Physician, Otologist, Audiologist or Hearing Aid Dealer.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For hearing care benefits to be available, such care must be Medically Necessary and you must receive such care on or after your Coverage Date.

In addition to the Definitions of this benefit booklet, the following definitions are applicable to this Benefit Section:

- AUDIOLOGIST.....means a duly licensed audiologist.
- HEARING AID DEALER.....means a Provider licensed to make and provide hearing aids to you.
- OTOLOGIST.....means a duly licensed otologist or otolaryngologist.

Benefit Period

Your hearing care benefit period begins on the first date a Covered Service is received after your Coverage Date and continues for a period of 36 consecutive months thereafter. Later benefit periods will begin on the first date a Covered Service is received following the expiration of your prior benefit period.

Covered Services

Benefits will be provided under this Benefit Section for the following:

- Audiometric Examination
- Hearing Aid Evaluation
- Conformity Evaluation
- Hearing Aids

Benefits will be limited to one Covered Service(s) of each type listed above per benefit period.

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.
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.

**Benefit Payment for Hearing Care**

Benefits for hearing care Covered Services, other than audiometric examinations, will be payable at 100% of the Claim Charge after you have met your program deductible.

Benefits for audiometric examinations will be payable at 100% of the Eligible Charge or 100% of the Maximum Allowance after you have met your program deductible.

Benefits for hearing care Covered Services other than audiometric examinations will be provided up to a maximum of $1,500 every 36 months.
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 booklet (see provisions entitled “Medicare Eligible Covered Persons” in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet 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 Health Care 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 Health Care Plan.

When you have a Claim, you must send the Claim Administrator 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.
EXCLUSIONS - WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— Hospitalization, services and supplies which are not Medically Necessary.

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician’s office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient’s condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

— Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician’s office or Hospital Outpatient department.

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other 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.
The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator’s decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers’ Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers’ Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program.

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Care Program.

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this benefit booklet.

— Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.

— Blood derivatives which are not classified as drugs in the official formularies.

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the
refractive state of the eye, except as specifically mentioned in this benefit booklet.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

— Routine foot care, except for persons diagnosed with diabetes.

— Immunizations, unless otherwise specified in this benefit booklet.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability or mental disability.

— Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet.

— Hypnotism.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

— Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet.

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

— Nutritional items such as infant formulas, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements, other than those specifically named in this benefit booklet.

— Elective abortions.

— Reversals of sterilization.

— Services and supplies rendered or provided for the treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination and all forms of in-vitro fertilization unless otherwise stated in the Benefit Highlights.

— Naprapathic services.
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 Health Care 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 Health Care Plan if no other group coverages were involved. It is your obligation to notify the Claim Administrator 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 Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.

2. When a dependent child receives services, the birthdays of the child’s parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent’s birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this “birthday” type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

   — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

   — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to
notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

In order to prevent duplicate payment of benefits for a Claim, the Claim 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 Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.
HOW TO FILE A CLAIM AND APPEALS PROCEDURES

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your identification card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator’s records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Retiree Benefits Department or from the Claim Administrator’s office.

2. Attach copies of all bills to be considered for benefits. These bills must include the Provider’s name and address, the patient’s name, the diagnosis, the date of service and a description of the service and the Claim Charge.

3. Mail the completed Claim Form with attachments to:
   Blue Cross and Blue Shield of Illinois
   P. O. Box 805107
   Chicago, Illinois 60680-4112

In any case, Claims must be filed no later than twelve months after the date a service is received. Claims not filed within twelve months from the date a service is received, will not be eligible for payment.

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator’s office.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Claim Administrator will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator does not process a Claim within this 30-day period, you or your valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the day payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim
Administrator will usually notify you, your valid assignee, or your authorized representative when all information required to process a Claim in accordance with the terms of the benefit program within 30 days of the Claim’s receipt has not been received. (For information regarding assigning benefits, see “Payment of Claims and Assignment of Benefits” provisions in the GENERAL PROVISIONS section of this benefit booklet.)

**If a Claim Is Denied or Not Paid in Full**

If the claim for benefits is denied, you or your authorized representative shall be notified in writing of the following:

a. The reasons for determination;

b. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative, medical policy or protocol for the determination;

c. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

e. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or external review);

f. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

h. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

i. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;

j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant’s medical circumstances, if the determination was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
k. In the case of a determination of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such Claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification.

If You Need Assistance
If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator’s offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday. Customer service hours and operations are subject to change without notice.

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your identification card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INQUIRIES AND COMPLAINTS
An “Inquiry” is a general request for information regarding claims, benefits, or membership.

A “Complaint” is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with an Adverse Benefit Determination (or partial determination), then you have the right to a Claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact customer service at the number on the back of your identification card, or you may write to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact customer service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of
receipt by customer service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted. If an Inquiry or Complaint is not resolved to your satisfaction, you may appeal to the Claim Administrator.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees or a Provider.

The following is the contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For Complaints and general Inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
Consumer_complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

a. **Urgent Care Clinical Claim** is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

b. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

c. **Post-Service Claim** is notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.
### Urgent Care Clinical Claims*

<table>
<thead>
<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>24 hours**</td>
</tr>
<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim</td>
<td>48 hours after receiving notice</td>
</tr>
<tr>
<td>information to the Claim Administrator within:</td>
<td></td>
</tr>
<tr>
<td><strong>The Claim Administrator must notify you of the Claim determination (whether adverse or not):</strong></td>
<td></td>
</tr>
<tr>
<td>if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:</td>
<td>72 hours</td>
</tr>
<tr>
<td>after receiving the completed Claim (if the initial Claim is incomplete), within:</td>
<td>48 hours</td>
</tr>
</tbody>
</table>

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your identification card as soon as possible to submit an Urgent Care Clinical Claim.

**Notification may be oral unless the claimant requests written notification.

### Pre-Service Claims

<table>
<thead>
<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your Claim is filed improperly, the Claim Administrator must notify you within:</td>
<td>5 days*</td>
</tr>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>15 days</td>
</tr>
<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:</td>
<td>45 days after receiving notice</td>
</tr>
<tr>
<td><strong>The Claim Administrator must notify you of the Claim determination (whether adverse or not):</strong></td>
<td></td>
</tr>
<tr>
<td>if the initial Claim is complete, within:</td>
<td>15 days**</td>
</tr>
<tr>
<td>after receiving the completed Claim (if the initial Claim is incomplete), within:</td>
<td>30 days</td>
</tr>
<tr>
<td>If you require post-stabilization care after an Emergency within:</td>
<td>the time appropriate to the circumstance not to exceed one hour after the time of request</td>
</tr>
</tbody>
</table>

*Notification may be oral unless the claimant requests written notification.
This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

**Post-Service Claims**

<table>
<thead>
<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:</td>
<td>45 days after receiving notice</td>
</tr>
</tbody>
</table>

**The Claim Administrator must notify you of any adverse Claim determination:**

| if the initial Claim is complete, within: | 30 days*                        |
| if the initial Claim is incomplete, within: | 45 days                        |

*This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

**Concurrent Care**

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

**CLAIM APPEAL PROCEDURES - DEFINITIONS**

An “Adverse Benefit Determination” means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, in response to a Claim, Pre-Service Claim or Urgent Care Clinical Claim, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Group’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.
Urgent Care/Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Claim Administrator will render a decision on the appeal within 24 hours after it receives the requested information, but not more than 72 hours from the appeal request.

Standard or Non-Urgent Appeals

The Claim Administrator will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Under your health benefit plan, there is one level of internal appeal available to you. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your identification card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a Claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination.
In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, with to file a complaint or wish to take up your matter with the IDOI, you may use either address below:

IDOI Consumer Division
320 W. Washington St.
Springfield, Illinois 62767
1-217-782-4515

or

IDOI Consumer Division
122 S. Michigan Ave., 19th Floor
Chicago, Illinois 60603
1-312-814-2420


Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.

Send a written appeal request to:
The Claim Administrator
Claim Review Section
P.O. Box 2401
Chicago, Illinois 60690

To file an appeal or if you have questions, please call 800-538-8833 (TTY/TDD:711, send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members (BAM) at bcbsil.com

During the course of your internal appeal(s), the Claim Administrator will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by the Claim Administrator in connection with the appealed Claim, as well as any new or additional rationale for a determination at the internal ap-
peals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. The Claim Administrator may extend the time period described in this benefit booklet for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial determination of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.

**Timing of Non-Urgent Appeal Determinations**

Upon receipt of a non-urgent concurrent pre-service or post-service appeal, the Claim Administrator will notify the party filing the appeal within five business days of all the information needed to review the appeal.

The Claim Administrator will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 calendar days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 30 calendar days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you have already received the service.

If the appeal is related to administrative matters or Complaints, the Claim Administrator will render a decision of a pre-service or post-service appeal as soon as practical, but in no event more than 60 business days after receipt of all required information.

**Notice of Appeal Determination**

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and a statement describing determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

4. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final determination on internal and external appeal;

5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative;

6. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

9. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

10. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;

11. A description of the standard that was used in denying the claim and a discussion of the decision;

12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;

13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review;

14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the
Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a Provider appeal.

If the Claim Administrator’s or your Employer’s decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the determination and issue a final decision. Your external review rights are described in the **STANDARD EXTERNAL REVIEW** section below.

You may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the Complaint. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

**STANDARD EXTERNAL REVIEW**

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO). The external review is at no charge to the member.

An “**Adverse Benefit Determination**” means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

A “**Final Internal Adverse Benefit Determination**” means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator’s internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt
of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:

a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

c. You have exhausted the Claim Administrator’s internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the EXHAUSTION section below for additional information and exhaustion of the internal appeal process; and

d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor’s Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the determination of benefits.
The IRO must provide the following:

a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

b. Timely notification to you or your authorized representative, in writing, of the request’s eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator’s internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned
IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;
(2) The attending health care professional’s recommendation;
(3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
(4) The terms of your plan to ensure that the IRO’s decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
(6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
(7) The opinion of the IRO’s clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous determination);
(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan’s decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. Request for expedited external review. Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STAN-
DARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator’s internal claims and appeals process.

4. Notice of final external review decision. The Claim Administrator’s contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to com-
ply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.
GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR’S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers (“Administrator Providers”) in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator’s contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider’s Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage (“ADP”) applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. 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 the Claim Administrator’s separate financial arrangements with Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital’s Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance.
amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

**BlueCard® Program**

Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, the Claim Administrator will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever you access Covered Services outside the Claim Administrator’s service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.
b. The provider has negotiated with the Host Blue a price of $80, even though the provider’s standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

**Negotiated (non-BlueCard Program) National Account Arrangements**

As an alternative to the BlueCard Program, your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A,
BlueCard Program) made available to the Claim Administrator by the Host Blue.

Non-Participating Healthcare Providers Outside The Claim Administrator’s Service Area

a. Liability Calculation

(1) In General

When Covered Services are provided outside of the Claim Administrator’s service area by non-participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Booklet for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, the Claim Administrator may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then the Claim Administrator may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area (and described in Section (1) above); or

2. The following:

   (i) For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or

   (ii) For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

Value-Based Programs Negotiated Arrangements

If the Claim Administrator enters into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, Blue Cross and Blue Shield of Illinois will follow the same procedures
for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

**Blue Cross Blue Shield Global Core**

If you are outside the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

**Inpatient Services**

In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact the Claim Administrator to obtain Preauthorization for non-emergency Inpatient services.**

**Outpatient Services**

Outpatient Services are available for Emergency Care, Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

**Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider’s itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from the Plan, the Blue Cross Blue Shield Global Core Service Center or online at
www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

**Servicing Plans**

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans ("Servicing Plans") to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator’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 the Claim Administrator 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 Health Care 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 the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, 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.

**Claim Administrator’s Separate Financial Arrangements with Pharmacy Benefit Managers**

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as “Pharmacy Benefit Managers”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.
Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). The Claim Administrator may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

c. A Covered Person’s claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

c. The use of an adjective such as Participating, Administrator 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.

d. 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 ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator’s records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator’s records. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, retiree benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and
records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

7. PHYSICAL EXAMINATION AND AUTOPSY

The Claim Administrator, at its own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

8. VALUE BASED DESIGN PROGRAMS

The Claim Administrator and your Employer has the right to offer medical management programs, a quality improvement programs and health behavior wellness, maintenance, or improvement program that allows for a reward, a contribution, a penalty, a differential in premiums or medical, prescription drug or equipment Copayments, Coinsurance or deductibles, or costs or a combination of these incentives or disincentives for participation in any such program offered or administered by the Claim Administrator or an entity chosen by the Claim Administrator to administer such program. In addition, discount programs for various health and wellness-related or insurance-related or other items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Contact your Employer for additional information regarding any value based programs offered by your Employer.

9. OVERPAYMENT

If your group’s benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error (“Overpayment”), your group’s plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to whom or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your Group’s benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or
b. Any future benefit payment made to any person or entity under another blue Cross and Blue Shield administered ASO benefit program; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future benefit payment owed to one or more Participating or Non-Participating Providers.

Further, the Claim Administrator has the right to reduce your benefit plan’s or policy’s payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield’s plan or policy’s Overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield’s plan or policy.
If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider’s Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage (“ADP”) applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”)
ASO-1

Effective Date: January 1, 2018
www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and does not assume any financial risk or obligation with respect to claims.
Schedule B-2

(WI employees)

(Blue Cross Blue Shield of Illinois)
Your Health Care Benefit Program

Farm Credit Foundations
Retiree WISC Consumer Choice 2
201739

Administered by:

BlueCross BlueShield of Illinois
A message from

Farm Credit Foundations

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Sincerely,
Farm Credit Foundations
NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.
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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 booklet.

THE UTILIZATION REVIEW PROGRAM

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet.

Lifetime Maximum for all Benefits

Unlimited

Individual Coverage Deductible** 

$3,450 per benefit period

Family Coverage Deductible** 

$6,900 per benefit period

Individual Coverage Out-of-Pocket Expense Limit**

— Participating Provider $3,450 per benefit period

— Non-Participating Provider $6,900 per benefit period

— Non-Administrator Provider No limit

Family Coverage Out-of-Pocket Expense Limit**

— Participating Provider $6,900 per benefit period

— Non-Participating Provider $13,800 per benefit period

— Non-Administrator Provider No limit

HOSPITAL BENEFITS

Payment level for Covered Services from a Participating Provider:

— Inpatient Covered Services 100% of the Eligible Charge

— Outpatient Covered Services 100% of the Eligible Charge

Payment level for Covered Services from a Non-Participating Provider:

— Inpatient Covered Services 60% of the Eligible Charge

— Outpatient Covered Services 60% of the Eligible Charge

Payment level for Covered Services from a Non-Administrator Provider 100% of the Non-Participating Hospital Benefit Payment Level
Hospital Emergency Care
— Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider

— Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider

100% of the Eligible Charge

BLUE DISTINCTION/BLUE DISTINCTION PLUS

Transplants
— Blue Distinction Designated Center 100% of the Eligible Charge, no deductible

— Blue Distinction Plus Designated Center 100% of the Eligible Charge, no deductible

— Participating Provider 100% of the Eligible Charge

— Non-Participating Provider 60% 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

Payment level for Emergency Medical Care

100% of the Maximum Allowance

OTHER COVERED SERVICES
Payment level 100% of the Eligible Charge or Maximum Allowance
HEARING BENEFITS

Hearing examination 100% of the Claim Charge
Hearing Aids Maximum $1,500 (every 36 month)

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

**Should the Federal Government adjust the Deductible for High Deductible Plans as defined by the Internal Revenue Service, the Deductible amount in this benefit booklet will be adjusted accordingly.
DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ACUTE TREATMENT SERVICES.....means a 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/ or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Pro­gram or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist operating within the scope of his or her certifica­tion.

AMBULANCE TRANSPORTATION.....means local transportation in specially equipped certified ground and air ambulance options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this health care plan.

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE.....means the amount that represents the billed charges from the majority of the ambulance providers in the Chicago metro area, as submitted to the Claim Administrator.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an
ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An “Administrator Ambulatory Surgical Facility” means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Ambulatory Surgical Facility” means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

(ii) A clinical trial conducted under an FDA experimental/investigational new drug application, or

(iii) A drug that is exempt from the requirement of an FDA experimental/ investigational new drug application.

AVERAGE DISCOUNT PERCENTAGE (“ADP”).....means a percentage discount determined by the Claim Administrator that will be applied to a Provider’s Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator’s reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”) In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator’s contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.
BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorder and is operating within the scope of such license.

BILLED CHARGES.....means the total gross amounts billed by Providers to the Claim Administrator on a Claim, which constitutes the usual retail price that the Provider utilizes to bill patients or any other party that may be responsible for payment of the services rendered without regard to any payor, discount or reimbursement arrangement that may be applicable to any particular patient. This list of retail prices is also sometimes described in the health care industry as a “chargemaster.”

CARE COORDINATION.....means organized, information-driven patient care activities intended to facilitate the appropriate responses to participant’s health care needs cross the continuum of care.

CARE COORDINATION FEE.....means a fixed amount paid by a Blue Cross and/or Blue Shield plan to Providers.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

    (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

    (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

    (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and
(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A “Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse and is operating within the scope of such license; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who does not have a written agreement
with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharma-

CHIROPRACTOR.....means a duly licensed chiropractor and is operating

CLAIM.....means notification in a form acceptable to the Claim Administrator

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Pro-

CLAIM PAYMENT.....means the benefit payment calculated by the Claim

CLINICAL LABORATORY.....means a clinical laboratory which complies

A “Participating Clinical Laboratory” means a Clinical Laboratory which

A “Non-Participating Clinical Laboratory” means a Clinical Laboratory

A “Participating Clinical Laboratory” means a Clinical Laboratory which

A “Non-Participating Clinical Laboratory” means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.
CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor operating within the scope of his or her license.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Professional Counselor” means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker operating within the scope of his or her license.

A “Participating Clinical Social Worker” means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Social Worker” means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL STABILIZATION SERVICES.....means a 24-hour treatment, usually following acute treatment services for Substance Use Disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

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 Pri-
vate Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An “Administrator Coordinated Home Care Program” means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A “Non-Administrator Coordinated Home Care Program” means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

(i) A group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

(iv) Medicaid (Title XIX of the Social Security Act).

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.
(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

(x) A health plan under Section 5(e) of the Peace Corps Act.

(xi) State Children’s Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

DEDUCTIBLE.....means the amount of expense that you must incur in Covered Services before benefits are provided.

DENTIST.....means a duly licensed dentist operating within the scope of his or her license.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans and positron emission tomography (PET) scans.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services, when operating within the scope of such license.

An “Administrator Dialysis Facility” means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Dialysis Facility” means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.
DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person of the same or opposite sex which meets the following criteria:

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other’s common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner’s life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner’s will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider, when operating within the scope of such license.

A “Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, such Provider’s Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, the following amount:

(i) the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider’s Billed Charges, and (b) an amount determined by the Claim Administrator to be approximately 300% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider’s Billed Charges and (b) an amount determined by the Claim Administrator to be 300% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the Maximum Allowance cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 300% of the Provider’s Billed Charges (unless otherwise required by applicable law or arrangement with the Non-Participating Provider), provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to you.

In addition to the foregoing, the Eligible Charge will be subject in all respects to the Claim Administrator’s Claim Payment rules, edit and methodologies regardless of the Provider’s status as a Participating Provider or Non-Participating Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)
Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed charge for such Covered Services (unless otherwise required by applicable law or arrangement with the Non-Participating Provider).

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating Provider’s standard billed charge for such Covered Service (unless otherwise required by applicable law or arrangement with the Non-Participating Provider). (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an retiree of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowl-
edge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorders condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage under your Employer’s health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL or EXPERIMENTAL/INVESTIGATIONAL SERVICES AND SUPPLIES.....means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment for the condition being treated or, if any of such items required federal or other governmental agency approval, such approval was not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. As used herein, medical treatment includes medical, surgical, or dental treatment.

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;

- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
• the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-fixed programs in making its determination.

Although a Physician or Professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort. The Claim Administrator still may determine such services or supplies to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational.

Approval by a government or regulatory agency will be taken into consideration in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider, when operating within the scope of such license.

A “Participating Home Infusion Therapy Provider” means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Home Infusion Therapy Provider” means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service, when operating within the scope of such license.

A “Participating Hospice Care Program Provider” means a Hospice Care Program Provider that either: (i) has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

A “Non-Participating Hospice Care Program Provider” means a Hospice Care Program Provider that either: (i) does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice
Care Program Provider which has not been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

An “Administrator Hospital” means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Hospital” means a Hospital that does not meet the definition of an Administrator Hospital.

A “Participating Hospital” means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A “Non-Participating Hospital” means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INFERTILITY.....means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy.

INFUSION THERAPY.....means the administration of medication through a needle or catheter. It is prescribed when a patient’s condition is so severe that it cannot be treated effectively by oral medications. Typically, “Infusion Therapy” means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.
INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

LIFE-THREATENING DISEASE OR CONDITION.....means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST (“LMFT”).....means a duly licensed marriage and family therapist operating within the scope of his or her license.

A “Participating Marriage and Family Therapist” means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Marriage and Family Therapist” means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with Non-Participating Providers):
(i) the Provider’s billed charges, or;

(ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 300% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider’s standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 100% of the Claim Administrator’s rate for such Covered Service according to its current Schedule of Maximum Allowance. If there is no rate according to the Schedule of Maximum Allowance, then the Maximum Allowance will be 25% of Billed Charges.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).
MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits including Preauthorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions for the treatment of Mental Illness and Substance Use Disorder.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

“Serious Mental Illness”.....means the following mental disorders as classified in the current Diagnostic and Statistical Manual published by the American Psychiatric Association:

(i) Schizophrenia;
(ii) Paranoid and other psychotic disorders;
(iii) Bipolar disorders (hypomaniac, manic, depressive and mixed);
(iv) Major depressive disorders (single episode or recurrent);
(v) Schizoaffective disorders (bipolar or depressive);
(vi) Pervasive developmental disorders;
(vii) Obsessive-compulsive disorders;
(viii) Depression in childhood and adolescence;
(ix) Panic disorder;
(x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
(xi) Anorexia nervosa and bulimia nervosa.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.
NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist operating within the scope of his or her license.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist operating within the scope of his or her license.

A “Participating Optometrist” means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider operating within the scope of his or her license.

A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Orthotic Provider” means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Sub-
stance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider’s office, and where Legend Drugs and devices are dispensed under Prescriptions to the general public by a pharmacist licensed to dispense such drugs and devices under laws of the state in which he/she practices.

PHYSICAL THERAPIST.....means a duly licensed physical therapist operating within the scope of his or her license.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches operating within the scope of his or her license.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of his or her license.

PODIATRIST.....means a duly licensed podiatrist operating within the scope of his or her license.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this benefit booklet.
PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider operating within the scope of his or her license.

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you, and operating within the scope of such license.

An “Administrator Provider” means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Provider” means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A “Participating Provider” means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a ParticipatingProvider.

A “Non-Participating Provider” means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.
A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

A “Participating Prescription Drug Provider” means a Preferred or Non-Preferred Pharmacy, including but not limited to, an independent retail Pharmacy, chain or retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

A “Non-Participating Prescription Drug Provider” means a Pharmacy, including but not limited to, an independent retail Pharmacy, chain or retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which (i) has not entered into a written agreement with the Claim Administrator or (ii) has not entered into a written with any entity chosen by the Claim Administrator to administer its prescription drug program, for such Pharmacy to provide pharmaceutical services at the time Covered Services to participants in the benefit program at the time Covered Services are rendered.

PROVIDER INCENTIVE.....means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider’s compliance with agreed upon procedural and/or outcome measures for a particular population of participants.

PSYCHOLOGIST.....means a Registered Clinical Psychologist operating within the scope of such license.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois “Psychologists Registration Act” or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.
REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of his or her certification.

A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Registered Surgical Assistant” means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESCISSION.....means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums. A “Rescission” does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders. Requirements: the Claim Administrator requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

RESPITE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.
A “Participating Retail Health Clinic” means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Retail Health Clinic” means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ROUTINE PATIENT COSTS.....means the cost for all items and services consistent with the coverage provided under this benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

(i) The investigational item, device, or service, itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services, and operating within the scope of such license.

An “Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An “Uncertified Skilled Nursing Facility” means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.
SPEECH THERAPIST.....means a duly licensed speech therapist operating within the scope of his or her license.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE USE DISORDER.....means chemical dependency and/or the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disability or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such license. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An “Administrator Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility that does not meet the definition of an Administrator Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.
TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOBACCO USER.....means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your identification card or visit our Website at www.bcbsil.com.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

TRANSPLANT LODGING ELIGIBLE EXPENSE.....means the amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

VALUE BASED PROGRAM.....means an outcome based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

VIRTUAL PROVIDER.....means a licensed Provider who has a written agreement with the Claim Administrator to provide diagnosis and treatment of injuries and illnesses through either i) interactive audio communication (via telephone or other similar technology) or ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology) to you at the time services are rendered, operating within the scope of such license.

VIRTUAL VISIT.....means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the VIRTUAL VISITS provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.
UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of the following Covered Services before such services are rendered:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must call the Claim Administrator’s medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

  Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In the event of an emergency admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred.
• **Pregnancy/Maternity Admission Review**

Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

In the event of a maternity admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred.

Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

• **Skilled Nursing Facility Preadmission Review**

Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must call the Claim Administrator’s medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

• **Coordinated Home Care Program Preadmission Review**

Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must call the Claim Administrator’s medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

• **Private Duty Nursing Service Review**

Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever Private Duty Nursing Service is recommended by your Physician, you must call the Claim Administrator’s medical pre-notification number. This call must be made at least one business day prior to receiving services.
CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS—WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator’s determination of Medically Necessary care is limited to merely
whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator’s Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You
should call the Claim Administrator’s customer service number on your identification card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.
CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

The Claim Administrator’s Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Use Disorder. 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 may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below.

PREAUTHORIZATION REVIEW

- Inpatient Hospital Preauthorization Review

Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must Preauthorize for your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit. Participating and Non-Participating Providers may call the Mental Health Unit Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- Residential Treatment Center Preauthorization Review

Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness or Substance Use Disorder is recommended by your physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Mental Health Unit. This call must be made at least one day prior to scheduling of the admission. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.
• **Emergency Mental Illness or Substance Use Disorder Admission Review**

   Emergency Mental Illness or Substance Use Disorder Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

   In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may call the Mental Health Unit Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

• **Partial Hospitalization Treatment Program Review**

   Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

   In order to receive maximum benefits under this Health Care Plan, you must notify the Mental Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Participating and Non-Participating Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

   If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

• **Length of Stay/Service Review**

   Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

   Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.
An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary 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.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission or other health care service or supply does not meet the criteria for Medically Necessary care, some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, “EXCLUSIONS—WHAT IS NOT COVERED.”

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Mental Health Unit’s determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient Hospital admission or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.
MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit 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 Behavioral Health Practitioner 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 Behavioral Health Practitioner 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 Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO PREAUTHORIZE OR NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM (“IBMP”)

In addition to the benefits described in this benefit booklet, 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 the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.
MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.
THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator’s “Participating Provider Option” for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois Website at www.bcbsil.com for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms “Benefit Period” and “Deductible” as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

If you have Individual Coverage, each benefit period you must satisfy a $3,450 benefit program deductible before receiving benefits. After you have Claims for Covered Services in a benefit period which exceed this deductible amount, your benefits will begin.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has satisfied the family deductible amount of $6,900, it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the benefit program deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family deductible amount has been satisfied.

The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.
HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider’s charges.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
   - a semi-private room
   - a private room
   - an intensive care unit

2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.
BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider
When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 100% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital’s rate for its most common type of room with two or more beds.

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.

Non-Administrator Provider
When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received from a Non-Participating Provider.

OUTPATIENT HOSPITAL CARE
The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services
1. Surgery and any related Diagnostic Service received on the same day as the Surgery. In addition, benefits for Covered Services received for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care
8. Emergency Medical Care
9. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

10. Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

**BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES**

**Participating Provider**

Benefits will be provided at 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.

**Non-Administrator Provider**

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.

**Emergency Care**

Benefits for Emergency Accident Care will be provided at 100% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Accident Care will be subject to the Participating Provider program deductible.

Benefits for Emergency Medical Care will be provided at 100% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Medical Care will be subject to the Participating Provider program deductible.

However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually
transmitted disease or infection, will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Eligible Charge for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.
PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon’s office or Ambulatory Surgical Facility.
In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon’s office, Hospital or Ambulatory Surgical Facility if you are under age 19 and have been diagnosed with an autism spectrum disorder or a developmental disability.

For purposes of this provision only, the following definitions shall apply:

Autism spectrum disorder means.....a pervasive developmental disorder described by the American Psychiatric Association or the World Health Organization diagnostic manuals as an autistic disorder, atypical autism, Asperger Syndrome, Rett Syndrome, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified; or a special education classification for autism or other disabilities related to autism.

Developmental disability means.....a disability that is attributable to an intellectual disability or a related condition, if the related condition meets all of the following conditions:

- It is attributable to cerebral palsy, epilepsy or any other condition, other than a Mental Illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
- It manifested before the age of 22;
- It is likely to continue indefinitely; and
- It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.

3. Sterilization Procedures (even if they are elective).
4. Gender reassignment—benefits for Covered Services for gender reassignment Surgery, including related services and supplies, will be provided the same as for any other condition.

**Medical Care**

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Use Disorder Treatment Facility or a Residential Treatment Center or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician’s office or your Physician comes to your home.

**Consultations**

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician’s advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

**Diabetes Self-Management Training and Education**

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will also be provided for education programs that allow you to maintain a hemoglobin A1c level within the range identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management, operating within the scope of his/her license. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

**Diagnostic Service**—Benefits will be provided for those services related to covered Surgery or Medical Care.

**Emergency Accident Care**

**Emergency Medical Care**

**Electroconvulsive Therapy**

**Allergy Injections and Allergy Testing**
Chemotherapy

Occupational Therapy
Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

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.

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.

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.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Experimental/Investigational Treatment—Benefits will be provided for routine patient care in conjunction with experimental/investigational treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with an Approved Clinical Trial program. You and/or your Physician are encouraged
to call customer service at the toll-free number on your identification card in advance to obtain information about whether a particular clinical trial is qualified.

**Approved Clinical Trials**—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

**Acupuncture**—Benefits will be provided for acupuncture when rendered by a licensed acupuncturist.

**Durable Medical Equipment**—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

**Amino Acid-Based Elemental Formulas**—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

**Orthotic Devices**

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary.

**Outpatient Contraceptive Services**

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.
**Prosthetic Appliances**

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient’s condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

**Routine Pediatric Hearing Examination**—Benefits will be provided for routine pediatric hearing examinations.

**Pulmonary Rehabilitation Therapy**—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

**BENEFIT PAYMENT FOR PHYSICIAN SERVICES**

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

**Participating Provider**

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 100% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator’s benefit payment and the Provider’s charge to you.

**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.
Emergency Care

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.

However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Maximum Allowance for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
• Durable Medical Equipment Providers
• Home Infusion Therapy Providers
• Marriage and Family Therapists
• Occupational Therapists
• Optometrists
• Orthotic Providers
• Physical Therapists
• Prosthetic Providers
• Registered Surgical Assistants
• Retail Health Clinics
• Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator’s benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

• Physicians
• Podiatrists
• Psychologists
• Dentists
• Certified Nurse-Midwives
• Certified Nurse Practitioners
• Certified Clinical Nurse Specialists
• Certified Registered Nurse Anesthetists
• Chiropractors
• Clinical Social Workers
• Clinical Professional Counselors
• Clinical Laboratories
• Durable Medical Equipment Providers
• Home Infusion Therapy Providers
• Marriage and Family Therapists
• Occupational Therapists
• Optometrists
• Orthotic Providers
• Physical Therapists
• Prosthetic Providers
• Registered Surgical Assistants
• Retail Health Clinics
• Speech Therapists
• Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator’s benefit payment and such Provider’s charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.
OTHER COVERED SERVICES

This section of your benefit booklet describes “Other Covered Services” and the benefits that will be provided for them.

- The processing, transporting, storing, handling and administration of blood and blood components.

- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.

- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.

- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.

- Oxygen and its administration.

- Medical and surgical dressings, supplies, casts and splints.

- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia. Benefits for wigs will be limited to a lifetime maximum of $500.

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.

Benefits for ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility) will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance after you have met your program deductible.

Notwithstanding anything else described herein, Providers of ambulance services will be paid based on the amount that represents the billed charges from the majority of the ambulance Providers in the Chicago Metro area as submitted to the Claim Administrator. Benefits for Ambulance Transportation will be paid at the highest level available under this
benefit program. However, you will be responsible for any charges in excess of this amount.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

**Participating Providers are:**

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator’s benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.
Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator’s benefit payment and such Provider’s charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.
SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ 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 booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

— the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

— Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs.

— If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available,
your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

— Benefits for transportation and lodging are limited to a combined lifetime maximum of $10,000. The maximum amount that will be provided for lodging is $50 per person per day.

— In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:
  
  • Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
  
  • Travel time and related expenses required by a Provider.
  
  • Drugs which do not have approval of the Food and Drug Administration.
  
  • Storage fees.
  
  • Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
  
  • Meals.

**Blue Distinction Centers of Treatment (BDCT)**

Blue Distinction is a designation awarded by Blue Cross and Blue Shield companies to health care facilities that have demonstrated expertise in delivering quality health care. At the core of the program are Blue Distinction Centers for Specialty Care. Blue Distinction Centers are recognized for providing distinguished care in the areas of:

  • Transplants

The goal of Blue Distinction is to help you find specialty care while enabling and encouraging health care Providers to improve the overall quality and cost of care nationwide. Although your plan may require you to receive treatment at a Blue Distinction Center to get the highest level of benefits, you may still be covered at a non–Blue Distinction Center, but your out-of-pocket costs will usually be higher. Please refer to your Benefit Highlights section to see the payment levels for procedures performed at Blue Distinction Centers and procedures performed at other facilities. Blue Distinction benefit levels apply to facility benefits only. Travel and lodging benefits are the same as those outlined in the Human Organ Transplants section.

**CARDIAC REHABILITATION SERVICES**

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.
PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided for in this benefit booklet, (and notwithstanding anything in your benefit booklet to the contrary), the following preventive care services will be considered Covered Services and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service:

1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);

2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;

3. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and

4. with respect to women, such additional preventive care and screenings, not described in item 1. above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this preventive care services benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November, 2009).

The preventive care services described in items 1. through 4. above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Claim Administrator’s website at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, the Claim Administrator may use reasonable medical management techniques, including but not limited to, those related to setting and medical appropriateness to determine coverage.

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for the Copayment or Coinsurance for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment or Coinsurance for the office visit including the preventive health service.
Preventive Care Services for Adults (or others as specified):

1. Abdominal aortic aneurysm screening for men who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults over age 50
7. Depression screening
8. Type 2 diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
   - Hepatitis A
   - Hepatitis B
   - Herpes Zoster (Shingles)
   - Human papillomavirus
   - Influenza (Flu shot)
   - Measles, Mumps, Rubella
   - Meningococcal
   - Pneumococcal
   - Tetanus, Diphtheria, Pertussis
   - Varicella
12. Obesity screening and counseling
13. Sexually transmitted infections (STI) prevention
14. Tobacco use screening and cessation interventions for tobacco users
15. Syphilis screening for adults at higher risk
16. Physical Therapy to prevent falls in adults age 65 years and older who are at increased risk for falls
17. Hepatitis C virus (HCV) screening for adults at increased risk, and one time for everyone born 1945-1965
18. Hepatitis B virus screening for persons at high risk for infection
19. Counseling children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
20. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 and older
21. Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
22. Screening for high blood pressure in adults age 18 years or older
23. Screening for abnormal blood glucose and type II diabetes mellitus as part of cardiovascular risk assessment in adults who are overweight or obese.
24. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history or CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking), and (c) a calculated 10-year CVD risk of 10% or greater
25. Tuberculin testing for adults 18 years or older who are at risk of tuberculosis.

Preventive Care Services for Women (including pregnant women or others as specified):

1. Bacteriuria urinary tract screening or other infection screening for pregnant women
2. BRCA counseling about genetic testing for women at higher risk
3. Breast cancer chemoprevention counseling for women at higher risk
4. Breastfeeding comprehensive lactation support and counseling from trained providers, as well as, access to breastfeeding supplies for pregnant and nursing women. Electric breast pumps are limited to two per benefit period.
5. Cervical cancer screening
6. Chlamydia infection screening for younger women and women at higher risk
7. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
8. Domestic and interpersonal violence screening and counseling for all women
9. Daily supplements for women who may become pregnant
10. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
11. Gonorrhea screening for all women at higher risk
12. Hepatitis B screening for pregnant women at their first prenatal visit
13. HIV screening and counseling for sexually active women and prenatal HIV testing
14. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
15. Osteoporosis screening for women over age 60, depending on risk factors
16. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
17. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
18. Sexually transmitted infections (STI) counseling for women
19. Syphilis screening for all pregnant women or other women at increased risk
20. Well-woman visits to obtain recommended preventive services
21. Breast cancer mammography screenings, including breast tomosynthesis and, if Medically Necessary, a screening MRI
22. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal
23. Aspirin use for pregnant women to prevent preeclampsia
24. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

**Preventive Care Services for Children (or others as specified):**

1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Critical congenital heart defect screening for newborns
7. Major depression disorder (“MDD”) screening for adolescents
8. Development screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorder
10. Fluoride chemoprevention supplements for children without fluoride in their water source
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, weight and body mass index measurements
14. Hematocrit or hemoglobin screening
15. Hemoglobinopathies or sickle cell screening for all newborns
16. HIV screening for adolescents at higher risk
17. The following immunization vaccines for children from birth to age 18
   (doses, recommended ages, and recommended populations vary):
   - Hepatitis A
   - Hepatitis B
   - Human papillomavirus
   - Influenza (Flu shot)
   - Measles, Mumps, Rubella
   - Meningococcal
   - Pneumococcal
   - Tetanus, Diphtheria, Pertussis
   - Varicella
   - Haemophilus influenzae type b
   - Rotavirus
   - Inactivated Poliovirus
18. Lead screening for children at risk for exposure
19. Medical history for all children throughout development
20. Obesity screening and counseling
21. Oral health risk assessment for younger children up to ten years old
22. Phenylketonuria (PKU) screening for newborns
23. Sexually transmitted infections (STI) prevention and counseling for ad­
   olescents at higher risk
24. Tuberculin testing for children at higher risk of tuberculosis
25. Vision screening for all children
26. Autism screening
27. Tobacco use interventions, including education or brief counseling, to
   prevent initiation of tobacco use in school-aged children and adolescents
28. Newborn blood screening
29. Any other immunization that is required by law for a child. Allergy in­
   jections are not considered immunizations under this benefit provision.

The FDA-approved contraceptive drugs and devices currently covered under
this benefit provision are listed on the Women’s Contraceptive Coverage List.
This list is available on the Claim Administrator’s website at www.bcbsil.com
and/or by contacting customer service at the toll-free number on your identi­
fication card. Benefits are not available under this benefit provision for
contraceptive drugs and devices not listed on the Women’s Contraceptive Coverage List. You may, however, have coverage under other sections of this benefit booklet, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The Women’s Contraceptive Coverage List and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

Routine pediatric care, women’s preventive care (such as contraceptives) and/or Outpatient periodic health examinations Covered Services not included above will be subject to the deductible, Coinsurance, Copayments and/or benefit maximums previously described in your benefit booklet, if applicable.

Preventive care services received from a Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other routine Covered Services not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximums.

Benefits for vaccinations that are considered preventive care services will not be subject to any deductible, Coinsurance, Copayments and/or benefit maximum when such services are received from a Participating Provider or Participating Pharmacy.

Vaccinations that are received from a Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other vaccinations that are not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximum.

**WELLNESS CARE**

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

- Routine diagnostic medical procedures;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray.

**Participating Provider**

When you receive Covered Services for wellness care from a Participating Provider, benefits for wellness care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

**Non-Participating Provider**

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 100% of the Eligible Charge or
100% of the Maximum Allowance and will not be subject to the program deductible.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

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.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 100% of the Eligible Charge. Benefits for services rendered 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.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center. Substance Use Disorder Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.
DETOXIFICATION
Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this benefit booklet, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES
Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

BARIATRIC SURGERY
Benefits for Covered Services received for bariatric Surgery will be provided under the HOSPITAL BENEFIT and PHYSICIAN BENEFIT sections of this benefit booklet, the same as for any other condition.

MATERNITY SERVICE
Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours). Such an earlier discharge may only be provided if there is coverage and avail-
ability of a post-discharge Physician office visit or an in-home visit to verify the condition of the infant in the first 48 hours after discharge.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis of infertility.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility or the inability to attain or maintain a viable pregnancy, or sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this benefit booklet are available for the appliances, diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge;

4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; and
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered Cosmetic Surgery.

VIRTUAL VISITS

Benefits will be provided for Covered Services described in this benefit booklet for the diagnosis and treatment of non-emergency medical injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room office visit. Benefits for such Covered Services will only be provided if you receive them via consultation with a Virtual Provider who has a specific written agreement with the Claim Administrator to provide Virtual Visits to you at the time services are rendered. For more information about this benefit, you may visit the Claim Administrator’s website at www.bcbsil.com or call customer service at the number on the back of your identification card.

Benefits for Covered Services you receive through a Virtual Visit from a Participating Virtual Provider are subject to a Copayment of $44 per visit and then will be provided at 100% of the Maximum Allowance, after you have met your program deductible.

Benefits will not be provided for services you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with the Claim Administrator to provide Virtual Visits.

Note: Not all medical conditions can be appropriately treated through Virtual Visits. The Virtual Provider will identify any condition for which treatment by an in-person Provider is necessary.

PAYMENT PROVISIONS

Lifetime Maximum

Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $3,450, any additional eligible Claims for Participating Providers (except for those charges specifically excluded below)
during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for Covered Services for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or Non-Administrator Provider
- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

If you have Family Coverage and your family’s out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $6,900 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 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 you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $6,900, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the 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

• Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT

If you have Family Coverage and your family’s out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $13,800 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 will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program, Residential Treatment Center or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.
HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:
1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are not covered under the Hospice Care Program:
1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.
HEARING CARE PROGRAM

Your coverage includes benefits for hearing care when you receive such care from a Physician, Otologist, Audiologist or Hearing Aid Dealer.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For hearing care benefits to be available, such care must be Medically Necessary and you must receive such care on or after your Coverage Date.

In addition to the Definitions of this benefit booklet, the following definitions are applicable to this Benefit Section:

AUDIOLOGIST.....means a duly licensed audiologist.

HEARING AID DEALER.....means a Provider licensed to make and provide hearing aids to you.

OTOLOGIST.....means a duly licensed otologist or otolaryngologist.

Benefit Period

Your hearing care benefit period begins on the first date a Covered Service is received after your Coverage Date and continues for a period of 36 consecutive months thereafter. Later benefit periods will begin on the first date a Covered Service is received following the expiration of your prior benefit period.

Covered Services

Benefits will be provided under this Benefit Section for the following:

Audiometric Examination
Hearing Aid Evaluation
Conformity Evaluation
Hearing Aids

Benefits will be limited to one Covered Service(s) of each type listed above per benefit period.

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.


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.

**Benefit Payment for Hearing Care**

Benefits for hearing care Covered Services, other than audiometric examinations, will be payable at 100% of the Claim Charge after you have met your program deductible.

Benefits for audiometric examinations will be payable at 100% of the Eligible Charge or 100% of the Maximum Allowance after you have met your program deductible.

Benefits for hearing care Covered Services other than audiometric examinations will be provided up to a maximum of $1,500 every 36 months.
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 booklet (see provisions entitled “Medicare Eligible Covered Persons” in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet 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 Health Care 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 Health Care Plan.

When you have a Claim, you must send the Claim Administrator 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.
EXCLUSIONS - WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— Hospitalization, services and supplies which are not Medically Necessary.

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician’s office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient’s condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

— Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician’s office or Hospital Outpatient department.

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other 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.
The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED. The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator’s decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers’ Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers’ Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program.

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Care Program.

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this benefit booklet.

— Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.

— Blood derivatives which are not classified as drugs in the official formularies.

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the
refractive state of the eye, except as specifically mentioned in this benefit booklet.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

— Routine foot care, except for persons diagnosed with diabetes.

— Immunizations, unless otherwise specified in this benefit booklet.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability or mental disability.

— Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet.

— Hypnotism.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

— Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet.

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

— Nutritional items such as infant formulas, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements, other than those specifically named in this benefit booklet.

— Elective abortions.

— Reversals of sterilization.

— Services and supplies rendered or provided for the treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination and all forms of in-vitro fertilization unless otherwise stated in the Benefit Highlights.

— Naprapathic services.
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 Health Care 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 Health Care Plan if no other group coverages were involved. It is your obligation to notify the Claim Administrator 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 Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.

2. When a dependent child receives services, the birthdays of the child’s parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent’s birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this “birthday” type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

   — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

   — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to
notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

In order to prevent duplicate payment of benefits for a Claim, the Claim 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 Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.
HOW TO FILE A CLAIM
AND APPEALS PROCEDURES

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your identification card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator’s records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator’s office.

2. Attach copies of all bills to be considered for benefits. These bills must include the Provider’s name and address, the patient’s name, the diagnosis, the date of service and a description of the service and the Claim Charge.

3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield of Illinois
   P. O. Box 805107
   Chicago, Illinois 60680-4112

In any case, Claims must be filed no later than twelve months after the date a service is received. Claims not filed within twelve months from the date a service is received, will not be eligible for payment.

Should you have any questions about filing Claims, ask your Retiree Benefits Department or call the Claim Administrator’s office.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Claim Administrator will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator does not process a Claim within this 30-day period, you or your valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the day payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim
Administrator will usually notify you, your valid assignee, or your authorized representative when all information required to process a Claim in accordance with the terms of the benefit program within 30 days of the Claim’s receipt has not been received. (For information regarding assigning benefits, see “Payment of Claims and Assignment of Benefits” provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If a Claim Is Denied or Not Paid in Full

If the claim for benefits is denied, you or your authorized representative shall be notified in writing of the following:

a. The reasons for determination;

b. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative, medical policy or protocol for the determination;

c. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

e. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or external review);

f. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

h. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

i. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant’s medical circumstances, if the determination was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
k. In the case of a determination of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such Claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification.

If You Need Assistance
If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator’s offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday. Customer service hours and operations are subject to change without notice.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, IL 60680-4112
1-800-538-8833 Toll-free phone

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your identification card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INQUIRIES AND COMPLAINTS
An “Inquiry” is a general request for information regarding claims, benefits, or membership.

A “Complaint” is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with an Adverse Benefit Determination (or partial determination), then you have the right to a Claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact customer service at the number on the back of your identification card, or you may write to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact customer service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of
receipt by customer service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted. If an Inquiry or Complaint is not resolved to your satisfaction, you may appeal to the Claim Administrator.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees or a Provider.

The following is the contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For Complaints and general Inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
Consumer_complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

a. **Urgent Care Clinical Claim** is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

b. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

c. **Post-Service Claim** is notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.
### Urgent Care Clinical Claims*

<table>
<thead>
<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
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<tbody>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>24 hours**</td>
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<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:</td>
<td>48 hours after receiving notice</td>
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</table>
| The Claim Administrator must notify you of the Claim determination (whether adverse or not):  
  if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than: | 72 hours |
| after receiving the completed Claim (if the initial Claim is incomplete), within: | 48 hours |

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your identification card as soon as possible to submit an Urgent Care Clinical Claim.  
**Notification may be oral unless the claimant requests written notification.

### Pre-Service Claims

<table>
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<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
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<tbody>
<tr>
<td>If your Claim is filed improperly, the Claim Administrator must notify you within:</td>
<td>5 days*</td>
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<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>15 days</td>
</tr>
<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:</td>
<td>45 days after receiving notice</td>
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</table>
| The Claim Administrator must notify you of the Claim determination (whether adverse or not):  
  if the initial Claim is complete, within: | 15 days** |
| after receiving the completed Claim (if the initial Claim is incomplete), within: | 30 days |
| If you require post-stabilization care after an Emergency within: | the time appropriate to the circumstance not to exceed one hour after the time of request |

*Notification may be oral unless the claimant requests written notification.
**This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

**Post-Service Claims**

<table>
<thead>
<tr>
<th>Type of Notice or Extension</th>
<th>Timing</th>
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<tbody>
<tr>
<td>If your Claim is incomplete, the Claim Administrator must notify you within:</td>
<td>30 days</td>
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<tr>
<td>If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:</td>
<td>45 days after receiving notice</td>
</tr>
<tr>
<td>The Claim Administrator must notify you of any adverse Claim determination:</td>
<td></td>
</tr>
<tr>
<td>if the initial Claim is complete, within:</td>
<td>30 days*</td>
</tr>
<tr>
<td>after receiving the completed Claim (if the initial Claim is incomplete), within:</td>
<td>45 days</td>
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*This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

**Concurrent Care**

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

**CLAIM APPEAL PROCEDURES - DEFINITIONS**

An “Adverse Benefit Determination” means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, in response to a Claim, Pre-Service Claim or Urgent Care Clinical Claim, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Group’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.
Urgent Care/Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Claim Administrator will render a decision on the appeal within 24 hours after it receives the requested information, but not more than 72 hours from the appeal request.

Standard or Non-Urgent Appeals

The Claim Administrator will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Under your health benefit plan, there is one level of internal appeal available to you. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your identification card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a Claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination.
In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, with to file a complaint or wish to take up your matter with the IDOI, you may use either address below:

IDOI Consumer Division
320 W. Washington St.
Springfield, Illinois 62767
1-217-782-4515

or

IDOI Consumer Division
122 S. Michigan Ave., 19th Floor
Chicago, Illinois 60603
1-312-814-2420

<table>
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<tr>
<th>Your Right to Appeal</th>
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<tr>
<td>You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.</td>
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</table>

Send a written appeal request to:

The Claim Administrator
Claim Review Section
P.O. Box 2401
Chicago, Illinois 60690

To file an appeal or if you have questions, please call 800-538-8833 (TTY/TDD:711, send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members (BAM) at bcbsil.com

During the course of your internal appeal(s), the Claim Administrator will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by the Claim Administrator in connection with the appealed Claim, as well as any new or additional rationale for a determination at the internal ap-
peals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. The Claim Administrator may extend the time period described in this benefit booklet for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial determination of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.

Timing of Non-Urgent Appeal Determinations

Upon receipt of a non-urgent concurrent pre-service or post-service appeal, the Claim Administrator will notify the party filing the appeal within five business days of all the information needed to review the appeal.

The Claim Administrator will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 calendar days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 30 calendar days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you have already received the service.

If the appeal is related to administrative matters or Complaints, the Claim Administrator will render a decision of a pre-service or post-service appeal as soon as practical, but in no event more than 60 business days after receipt of all required information.

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and a statement describing determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

4. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final determination on internal and external appeal;

5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative;

6. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

9. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

10. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;

11. A description of the standard that was used in denying the claim and a discussion of the decision;

12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;

13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review;

14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the
Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a Provider appeal.

If the Claim Administrator’s or your Employer’s decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the determination and issue a final decision. Your external review rights are described in the **STANDARD EXTERNAL REVIEW** section below.

You may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the Complaint. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

**STANDARD EXTERNAL REVIEW**

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO). The external review is at no charge to the member.

An “**Adverse Benefit Determination**” means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

A “**Final Internal Adverse Benefit Determination**” means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator’s internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt
of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:

a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

c. You have exhausted the Claim Administrator’s internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the EXHAUSTION section below for additional information and exhaustion of the internal appeal process; and

d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor’s Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the determination of benefits.
The IRO must provide the following:

a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

b. Timely notification to you or your authorized representative, in writing, of the request’s eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator’s internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned
IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;
(2) The attending health care professional’s recommendation;
(3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
(4) The terms of your plan to ensure that the IRO’s decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
(6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
(7) The opinion of the IRO’s clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous determination);
(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan’s decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. Request for expedited external review. Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STAN-
DARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator’s internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator’s contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

**EXHAUSTION**

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.
External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.
GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR’S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator’s contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider’s Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. 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 the Claim Administrator’s separate financial arrangements with Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital’s Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance
amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

BlueCard® Program

Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, the Claim Administrator will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever you access Covered Services outside the Claim Administrator’s service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.
b. The provider has negotiated with the Host Blue a price of $80, even though the provider’s standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over – or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

**Negotiated (non-BlueCard Program) National Account Arrangements**

As an alternative to the BlueCard Program, your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A,
BlueCard Program) made available to the Claim Administrator by the Host Blue.

Non-Participating Healthcare Providers Outside The Claim Administrator’s Service Area

a. Liability Calculation

(1) In General

When Covered Services are provided outside of the Claim Administrator’s service area by non-participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Booklet for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, the Claim Administrator may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then the Claim Administrator may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area (and described in Section (1) above); or

2. The following:

   (i) For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or

   (ii) For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

Value-Based Programs Negotiated Arrangements

If the Claim Administrator enters into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, Blue Cross and Blue Shield of Illinois will follow the same procedures
for Value-Based Programs administration and Care Coordination Fees as
noted in the BlueCard Program section.

**Blue Cross Blue Shield Global Core**

If you are outside the Commonwealth of Puerto Rico, and the U.S. Virgin
Islands (hereinafter “BlueCard service area”), you may be able to take
advantage of the Blue Cross Blue Shield Global Core when accessing
Covered Services. The Blue Cross Blue Shield Global Core is unlike the
BlueCard Program available in the BlueCard service area in certain
ways. For instance, although the Blue Cross Blue Shield Global Core as­sists you with accessing a network of inpatient, outpatient and
professional providers, the network is not served by a Host Blue. As
such, when you receive care from providers outside the BlueCard service
area, you will typically have to pay the providers and submit the claims
yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or
hospital) outside the BlueCard service area, you should call the service
center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24
hours a day, seven days a week. An assistance coordinator, working with
a medical professional, can arrange a physician appointment or hospital­ization, if necessary.

**Inpatient Services**

In most cases, if you contact the service center for assistance, Hospitals
will not require you to pay for covered inpatient services, except for your
cost-share amounts/deductibles, Coinsurance, etc. In such cases, the
Hospital will submit your Claims to the service center to begin claims
processing. However, if you paid in full at the time of service, you must
submit a claim to receive reimbursement for Covered Services. **You must contact the Claim Administrator to obtain Preauthorization for
non-emergency Inpatient services.**

**Outpatient Services**

Outpatient Services are available for Emergency Care, Physicians, ur­
gent care centers and other Outpatient Providers located outside the
BlueCard service area will typically require you to pay in full at the time
of service. You must submit a claim to obtain reimbursement for
Covered Services.

**Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the BlueCard service area,
you must submit a claim to obtain reimbursement. For institutional and
professional Claims, you should complete a Blue Cross Blue Shield
Global Core International claim form and send the claim form with the
provider’s itemized bill(s) to the Blue Cross Blue Shield Global Core
Service Center (the address is on the form) to initiate Claims processing.
Following the instructions on the Claim form will help ensure timely
processing of your Claim. The Claim form is available from the Plan, the
Blue Cross Blue Shield Global Core Service Center or online at
www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

**Servicing Plans**

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans (“Servicing Plans”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator’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 the Claim Administrator 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 Health Care 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 the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, 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.

**Claim Administrator’s Separate Financial Arrangements with Pharmacy Benefit Managers**

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as “Pharmacy Benefit Managers”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.
Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). The Claim Administrator may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS
   a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.
   
   b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.
   
   c. A Covered Person’s claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS
   a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.
   
   b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.
   
   c. The use of an adjective such as Participating, Administrator 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.

d. 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 ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator’s records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator’s records. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, retiree benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and
records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

7. PHYSICAL EXAMINATION AND AUTOPSY

The Claim Administrator, at its own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

8. VALUE BASED DESIGN PROGRAMS

The Claim Administrator and your Employer has the right to offer medical management programs, a quality improvement programs and health behavior wellness, maintenance, or improvement program that allows for a reward, a contribution, a penalty, a differential in premiums or medical, prescription drug or equipment Copayments, Coinsurance or deductibles, or costs or a combination of these incentives or disincentives for participation in any such program offered or administered by the Claim Administrator or an entity chosen by the Claim Administrator to administer such program. In addition, discount programs for various health and wellness-related or insurance-related or other items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Contact your Employer for additional information regarding any value based programs offered by your Employer.

9. OVERPAYMENT

If your group’s benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error (“Overpayment”), your group’s plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your Group’s benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or
b. Any future benefit payment made to any person or entity under another blue Cross and Blue Shield administered ASO benefit program; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future benefit payment owed to one or more Participating or Non-Participating Providers.

Further, the Claim Administrator has the right to reduce your benefit plan’s or policy’s payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield’s plan or policy’s Overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield’s plan or policy.
REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider’s Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage (“ADP”) applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”)
ASO-1

Effective Date: January 1, 2018

www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and does not assume any financial risk or obligation with respect to claims.
BENEFIT SCHEDULE C

Prescription Coverage
(Group No. 1385)
Schedule
(Prescription Coverage)

(CVS Caremark)
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This section of your Benefit Schedule describes your benefits for prescription drug expenses. Your prescription drug benefits are administered by CVS Caremark, Inc.

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.

DEFINITIONS

AFFORDABLE CARE ACT (ACA) PREVENTIVE.....Under the ACA, there are certain drugs that are considered preventative. Examples of these medications include doctor-written prescriptions for women’s health preventive care, including Food and Drug Administration-approved contraceptive methods, preventive aspirin for men and women, iron supplements for children, folic acid for childbearing age or pregnant women, Vitamin D for at-risk adults over age 65, prescribed fluoride supplements for children under age six and tobacco cessation products. All preventive drugs and treatments require a doctor’s prescription under the preventive 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. The Formulary Drug list does not guarantee coverage and is modified from time to time.

GENERIC DRUG.....means a Prescription Drug which is not trademarked but is chemically equivalent to a Brand Name Drug. A generic drug is identical, or bioequivalent, to a brand name drug in dosage, safety, strength, quality, performance characteristics and intended use. You will pay the lowest copayment for generic drugs. Generics are equivalent to their brand-name counterparts, and are ensured by the Food and Drug Administration to be as safe and effective. However, generics are significantly less expensive than the brand name. To be sure you pay the lowest copayment, ask your doctor to prescribe generic medications, when appropriate.

GENERIC PREVENTIVE DRUG LIST.....Farm Credit Foundations understands that some medications can help prevent disease or help manage existing conditions to try and avoid future complications. For this reason, Farm Credit Foundations now offers a preventive drug list, which reduces your cost for select Generic Drugs that help prevent chronic health conditions, when taken regularly. If you take medications on the preventive Generic Drug list, you will have a $0 copayment for these medications even if you have not yet met your annual plan deductible.

LIFESTYLE DRUG.....means Prescription Drugs that are not generally considered medically necessary. You will pay the full cost of the prescription after a discount has been applied. Lifestyle drugs are typically drugs that are prescribed for non-medically necessary uses such as cosmetic Botox® and Propecia® for hair loss.

MAIL ORDER DRUG.....means approved drugs and medicines from a Caremark Mail Order Prescription Pharmacy, which provides its services to Participants or Covered Dependents under the Retiree Medical Plan.

MAIL ORDER PHARMACY.....means Caremark, which provides its services to Participants covered under the Retiree Medical Plan.

NETWORK RETAIL PHARMACY.....means a pharmacy or drug store which has entered into a service agreement with Caremark to provide benefits under the Retiree Medical Plan at specified rates to persons covered under the Retiree Medical Plan.

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 Retiree Medical Plan at specified rates to persons covered under the Retiree Medical Plan.

NON-PREFERRED BRAND DRUG.....means a trademarked Prescription Drug that may be on the Formulary Drug List but paid at a higher copayment than other medications. These are medications that have been patented for name and chemical content. Once the patent expires, generic drugs with a different name but the same chemical make-up typically become available. Non-preferred drugs are prescription drugs that are not generic or on the list of preferred drugs. Typically, non-preferred named drugs are the most expensive and/or have a comparable drug that is either generic or on the preferred list. Generally, these are higher-cost medications that have recently come on the market.
These drugs have the highest copayment. In most cases, an alternative preferred medication is available. Depending on your personal health care needs, there may be times when non-preferred drugs are right for you. In these situations, you will need to pay the non-preferred co-payment.

PREFERRED BRAND DRUG…..means a trademarked Prescription Drug that is included on Caremark’s Formulary Drug List. Preferred Brand Drugs are brand name drugs that are effective for treating specific condition and are more cost-effective than equivalent non-preferred drugs. Often there is a choice of medications you can take for the same condition. One or more of these medications may be a preferred drug under this plan. They cost generally more than generics, but less than non-preferred brand name drugs.

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.

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.

RETAIL DRUG…..means approved drugs and medicines purchased from a retail drug store or pharmacy.

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.

PRESCRIPTION DRUG COVERAGE

The cost of your medication will vary, depending on your Retiree Medical Plan election and the category of medication prescribed.

The Retail Drug expense portion of the Retiree Medical Plan 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.

Benefits will be provided as described below for Covered Expenses incurred for the purchase of approved drugs and medicines from a retail pharmacy. A Retail Drug Copayment will apply before benefits are paid.

The Mail Order Drug expense portion of the Retiree Medical Plan 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 should use this provision. Members may also obtain a 90 days’ supply of maintenance medications at a CVS retail location.

Prescriptions for certain medications (i.e., Specialty Drugs) must be filled through CVS Caremark’s Specialty Pharmacy. Specialty Drugs are typically drugs that must be refrigerated, that have a short shelf-life, are bio-tech drugs, and/or are expensive medications that are not typically stocked by other pharmacies. Prescriptions filled through the CVS Caremark Specialty Pharmacy are generally subject to the applicable Retail Drug Copayment.
### Prescription Schedule Consumer Choice 1 and Consumer Choice 2
#### WI Consumer Choice 1 and WI Consumer Choice 2

<table>
<thead>
<tr>
<th>Location</th>
<th>Generic Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Retail (30-Day Supply)</td>
<td>Subject to Same Deductible and Coinsurance as Other Medical Benefits</td>
</tr>
<tr>
<td>• Retail (90-Day Supply Select Pharmacies)</td>
<td>Preferred Brand</td>
</tr>
<tr>
<td>• Maintenance Choice (90-Day Supply at CVS and Target Pharmacies)</td>
<td>Non-Preferred Brand</td>
</tr>
<tr>
<td>• Mail Order (90-Day Supply)</td>
<td></td>
</tr>
<tr>
<td><strong>Generic Drug</strong></td>
<td><strong>Preferred Brand</strong></td>
</tr>
<tr>
<td><strong>Non-Preferred Brand</strong></td>
<td>Subject to Same Deductible and Coinsurance as Other Medical Benefits</td>
</tr>
<tr>
<td><strong>Affordable care Act (ACA)</strong></td>
<td>Preferred Brand</td>
</tr>
<tr>
<td><strong>Preventive</strong></td>
<td>Non-Preferred Brand</td>
</tr>
<tr>
<td><strong>Generic Preventive Drug List</strong></td>
<td>You pay 100% of Discounted Price (Does Not Apply to Deductible or Out-Of-Pocket Maximums)</td>
</tr>
<tr>
<td><strong>Lifestyle Drugs</strong></td>
<td></td>
</tr>
</tbody>
</table>

- **Note**: When a Generic Drug is available, but the Pharmacy dispenses the Brand Name Drug for any reason other than that the Physician indicated “dispense as written,” you will pay the brand name copayment (Non-Preferred or Preferred, as applicable) plus the difference between the cost of the brand name drug and the Generic Drug.

- **Use of Network Retail Pharmacy versus Non-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 applicable amounts noted in the chart above for the option you selected 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 then file a Claim with Caremark for reimbursement of eligible expenses within 12 months of purchase. If you use a Non-Network Retail Pharmacy, you will need to file the Claim with Caremark for reimbursement of Covered Expenses within 12 months of purchase. Regardless of whether you have your prescription filled at a Network Retail Pharmacy or at a Non-Network Retail Pharmacy, you will ultimately be responsible for paying the applicable amounts noted in the chart above.

### Diabetic Supplies

Your diabetic supply kit (swabs, lancets, syringes, and strips) are free when ordered with your insulin prescription/refill (mail order and retail). In addition, CVS Caremark has a disease management program available to help you manage your diabetes. Contact CVS Caremark for more information about this program at 1-800-841-5550.

### Compound Drugs

Pharmacy Compounding is a practice in which pharmacists combine, mix or alter drugs and/or ingredients to create unique medications to meet a specific need. Traditional compounding customizes a drug for someone who is allergic to a dye or preservative in an FDA approved medicine, or compounding a liquid dosage form specifically for a younger patient, etc. However, compounding may include mixing or reconstituting commercial products outside of the product’s approved labeling. Compound drugs are subject to pre-authorization or may be excluded from the Formulary Drug List to ensure appropriate utilization based on evidence-based medicine guidelines.
CVS Caremark’s Specialty Pharmacy

Certain medications may need to be filled through CVS Caremark’s Specialty Pharmacy.

**Specialty pharmaceuticals** are drug therapies developed to treat a wide range of complex chronic conditions. They are generally developed to serve a relatively small population of patients, most of whom have progressively severe diseases. Patients tend to be on these medications long-term, most for life (some exceptions include RSV, infertility and Hepatitis C). These drugs may be biologically derived; many require special handling and specialized training for mixing and administration, and are often very expensive—from several thousand to hundreds of thousand per year. Specialty medications must be dispensed by CVS Caremark specialty pharmacies and cannot be obtained through regular CVS Network pharmacies.

**Specialty Guideline Management (SGM)** is a program that helps to ensure appropriate utilization for specialty medications based on evidence-based medicine guidelines and consensus statements. Patient progress is continually assessed to determine whether appropriate therapeutic results are achieved.

CVS Caremark Specialty Guideline Management extends beyond pre-authorization ensuring the specialty drug is safe and effective for the patient, the drug is properly used, inappropriate utilization is avoided and unsafe or ineffective therapies are discontinued in a timely manner.

Certain specialty drugs are subject to specialty step therapy to encourage the clinically effective lowest cost drug as the first line of therapy. If you have questions regarding step therapy, you or your physician should contact Caremark Specialty at 1-800-237-2767.

Specialty drugs may be prescribed for the following therapies:

- Asthma
- Crohn’s disease
- Cystic fibrosis
- Growth hormone and related disorders
- Hematopoietics
- Hemophilia, von Willebrand disease and related bleeding disorders
- Hepatitis C
- HIV
- Hormonal therapies
- Immune disorders
- Infertility
- Lysosomal storage disorders
- Macular degeneration
- Multiple sclerosis
- Oncology
- Osteoarthritis
- Osteoporosis
- Psoriasis
- Pulmonary arterial hypertension
- Pulmonary disorders
- Renal disorder
- Rheumatoid arthritis
- RSV prevention
- Transplant
EXCLUSIONS

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 Retiree 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 Retiree 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.

COORDINATION OF BENEFITS SECTION

This Retiree Medical Plan will not coordinate prescription drug benefits with another plan if coverage under this Retiree Medical Plan is secondary. In other words, if your prescription drug coverage under this Retiree Medical Plan is secondary to your prescription drug coverage under some other health care plan, this Retiree Medical Plan will not provide you any benefits for prescription drug coverage. It is your obligation to notify CVS Caremark of the existence of such other group coverages.

CVS CAREMARK INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

DEFINITIONS

The following terms are used herein to describe the claims and appeals review services provided by CVS Caremark:

Administrative Denial – An Adverse Benefit Determination which is based solely on the terms of the Plan, including the preferred drug lists or formularies selected by the Plan Sponsor, and which does not involve a determination of Medical Necessity.
Adverse Benefit Determination – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. An Adverse Benefit Determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Plan benefit based on the application of a utilization review process or on a determination of a Plan member’s eligibility to participate in the Plan. An Adverse Benefit Determination also includes a failure to cover a Plan benefit because use of the benefit is determined to be experimental, investigative, or not Medically Necessary or appropriate.

Claim – A request for a Plan benefit that is made in accordance with the Plan’s established procedures for filing benefit claims.

Medically Necessary (Medical Necessity) – Medications, health care services or products are considered Medically Necessary if:

☐ Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;

☐ Use of the medication, service, or product is based on recognized standards for the health care specialty involved;

☐ Use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and

☐ Use of medication, service or product is not solely for the convenience of the member, member’s family, or provider.

Post-Service Claim – A Claim for a Plan benefit that is not a Pre-Service Claim.

Pre-authorization – CVS Caremark’s pre-service review of a member’s initial request for a particular medication. CVS Caremark will apply a set of pre-defined medical criteria to determine whether there is need for the requested medication.

Pre-Service Claim – A Claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include member requests for pre-authorization.

Urgent Care Claim – A Claim for a medication, service, or product where a delay in processing the Claim (i) could seriously jeopardize the life or health of the member, and/or could result in the member’s failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the member’s condition, would subject the member to severe pain that cannot be adequately managed without the requested medication, service, or product. CVS Caremark will defer to the member’s attending health care provider as to whether or not the member’s Claim constitutes an Urgent Care Claim.

CLAIMS AND APPEALS PROCESS

Pre-authorization Review:

CVS Caremark will implement the prescription drug cost containment programs by comparing member requests for certain medicines and/or other prescription benefits against pre-defined medical criteria specifically related to use of those medicines or prescription benefits before those prescriptions are filled. If CVS Caremark determines that the member’s request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.
Review Against the Plan’s Terms:

A member’s request for a particular drug or benefit will be compared against the preferred drug lists or formularies selected by the Employer before the member’s prescription is filled. If CVS Caremark determines that the member’s request for a drug or benefit cannot be approved based on the terms of the Plan, including the preferred drug lists or formularies selected by the Employer, that determination will constitute an Administrative Denial.

Appeals of Adverse Benefit Determinations:

If an Adverse Benefit Determination is rendered on the member’s Claim, the member may file an appeal of that determination. The member’s appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS Caremark within 180 days after the member receives notice of the Adverse Benefit Determination. If the Adverse Benefit Determination is rendered with respect to an Urgent Care Claim, the member and/or the member’s attending physician may submit an appeal by calling CVS Caremark.

The member’s appeal should include the following information:

☐ Name of the person the appeal is being filed for;
☐ CVS Caremark Identification Number;
☐ Date of birth;
☐ Written statement of the issue(s) being appealed;
☐ Drug name(s) being requested; and
☐ Written comments, documents, records or other information relating to the Claim.

The member’s appeal and supporting documentation may be mailed or faxed to:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
(Fax) 1-866-443-1172

Physicians may submit urgent appeal requests by calling the physician-only toll-free number: 1-855-465-0027.

CVS CAREMARK’S REVIEW:

The review a member’s Claim or appeal of an Adverse Benefit Determination will be conducted in accordance with the requirements of the terms of the Plan and any applicable laws. Members will be accorded all rights granted to them under the terms of the Plan and any applicable laws.

Review of Adverse Benefit Determinations of Pre-Service Clinical Claims

CVS Caremark will provide the first-level review of appeals of Pre-Service clinical Claims. Such Claims will be reviewed against pre-determined medical criteria relevant to the drug or benefit being requested. If the member’s first-level appeal is denied, the member may appeal CVS Caremark’s decision and request an additional second-level Medical Necessity review. The review of whether the requested drug or benefit is Medically Necessary will be conducted by an Independent Review Organization (IRO).

Review of Administrative Denials

CVS Caremark provides a single level of appeal for Administrative Denials. Upon receipt of such an appeal, CVS Caremark will review the member’s request for a particular drug or benefit against the terms of the Plan, including the preferred drug lists or formularies selected by the Employer.
Timing of Review:

- **Pre-Authorization Review** – CVS Caremark will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim within 72 hours.

- **Pre-Service Clinical Claim Appeal** – CVS Caremark will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service clinical Claim within 15 days after it receives the member’s appeal. If CVS Caremark renders an Adverse Benefit Determination on the first-level appeal of the Pre-Service Claim, the member may appeal that decision by providing the information described above. A decision on the member’s second-level appeal of the Adverse Benefit Determination will be made (by the IRO) within 15 days after the new appeal is received. If the member is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first- and second-level appeals, combined).

- **Administrative Denial or Post-Service Claim Appeal** – CVS Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim or on an Administrative Denial within 60 days after it receives such appeal.

Scope of Review:

During its pre-authorization review, first-level review of the appeal of a Pre-Service clinical Claim, or review of a Post-Service Claim or Administrative Denial, CVS Caremark shall:

- Take into account all comments, documents, records and other information submitted by the member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;

- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;

- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly situated members; and

- Provide a review that does not afford deference to the initial Adverse Benefit Determination and is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).

If a member appeals CVS Caremark’s denial of a Pre-Service clinical Claim, and requests an additional second-level Medical Necessity review by an IRO, the IRO shall:

- Consult with an appropriate health care professionals who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);

- Identify the health care professional, if any, whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination; and

- Provide for an expedited review process for Urgent Care Claims.
Notice of Adverse Benefit Determination:

Following the review of a member’s Claim, CVS Caremark will notify the member of any Adverse Benefit Determination in writing. (Decisions on Urgent Care Claims will be also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to pertinent Plan provision on which the Adverse Benefit Determination was based;
- A statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and
- If the Adverse Benefit Determination is based on a Medical Necessity, either the IRO’s explanation of the scientific or clinical judgment for the IRO’s determination, applying the terms of the Plan to the member’s medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

AUTHORITY AS CLAIMS FIDUCIARY:

In its capacity as Claims Administrator of the prescription benefit component of the Plan, CVS Caremark shall serve as the claims fiduciary with respect to preauthorization review of prescription drug benefit Claims arising under the Plan, first-level review of appeals of Pre-Service clinical Claims, and review of Post-Service Claims and Administrative Denials. CVS Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties. CVS Caremark is not responsible for the conduct of any second-level Medical Necessity review performed by an IRO.

CVS CAREMARK EXTERNAL REVIEW PROCEDURES

CVS Caremark Federal External Review Services

A Plan member who receives a Final Adverse Benefit Determination (as defined below) of a Claim for prescription drug benefits may be permitted to further appeal that denial using the Federal External Review Process that is described below. This external review process provides Plan members with another option for protesting the denial of their Claim for prescription benefits. CVS Caremark will administer Plan Sponsors’ Federal External Review process as described herein.

DEFINITIONS

The following terms are used herein to describe the Federal External Review services provided by CVS Caremark:

**Adverse Benefit Determination** – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. Such denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) may apply to both clinical and non-clinical determinations. However, only Adverse Benefit Determinations of a Claim Involving Medical Judgment will be eligible for External Review.

**Claim** – A request for a Plan benefit that is made in accordance with the Plan’s established procedures for filing benefit claims.
Final Internal Adverse Benefit Determination – An Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process, or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the “deemed exhaustion” rules of the Patient Protection and Affordable Care Act (ACA).

Independent Review Organization (IRO) – An entity that conducts independent external reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations.

Claim Involving Medical Judgment – A Claim for prescription drug benefits involving, but not limited to, decisions based on the Plan’s standards for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or involving determinations as to whether a treatment is experimental or investigational.

FEDERAL EXTERNAL REVIEW PROCESS (NON-EXPEDITED)

Request for Review:

A Plan member whose Claim Involving Medical Judgment is denied may request, in writing, an External Review of such Claim within four months after receiving notice of the Final Internal Adverse Benefit Determination. The member’s request should include the member’s name, contact information including mailing address and daytime phone number, member ID number, and a copy of the coverage denial. The member’s request for external review and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark
External Review Appeals Department MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
(Fax): 1-866-443-1172

Preliminary Review:

Within five days of receiving a Plan member’s request for external review, CVS Caremark will conduct a “preliminary review” to ensure that the request qualifies for external review. In this preliminary review, CVS Caremark will determine whether:

☐ The member is or was covered under the Plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, was covered at the time the prescription drug benefit was provided;
☐ The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the member’s failure to meet the Plan’s requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for Federal External Review;
☐ The member has exhausted the Plan’s internal appeals process (unless the member’s Claim is “deemed exhausted” within the meaning of the ACA); and
☐ The member has provided all the information and forms necessary to process the external review.

In addition, CVS Caremark will review the member’s request for external review to determine whether it involves a Claim Involving Medical Judgment. If CVS Caremark determines that the request does not involve a Claim Involving Medical Judgment, it will forward the member’s request for external review to an IRO for further review. The IRO will determine whether the member’s request for external review involves a Claim Involving Medical Judgment as soon as possible.

Within one day after completing its preliminary review, CVS Caremark will notify the member, in writing, that: (i) the member’s request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.
Referral to IRO:

If the member’s request for external review is complete and the member’s Claim is eligible for external review, CVS Caremark will assign the request to one of the IROs with which CVS Caremark has contracted. The IRO will notify the member of its acceptance of the assignment. The member will then have 10 days to provide the IRO with any additional information the member wants the IRO to consider.

The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Plan and the Plan Sponsor. The IRO may consider information beyond the records for the member’s denied Claim, such as:

- The member’s medical records;
- The attending health care professional’s recommendations;
- Reports from appropriate health care professionals and other documents submitted by the Plan, the member, or the member’s treating physician;
- The terms of the Plan to ensure that the IRO’s decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national, or professional medicine societies, boards, and associations;
- Any applicable clinical review criteria developed and used on behalf of the Plan (unless the criteria are inconsistent with the terms of the Plan or applicable law); and
- The opinion of the IRO’s clinical reviewer(s) after considering all information and documents applicable to the member’s request for external review, to the extent such information or documents are available and the IRO’s clinical reviewer(s) considers it appropriate.

Timing of IRO’s Determination:

The IRO will provide the member and CVS Caremark (on behalf of the Plan) with written notice of its final external review decision within 45 days after the IRO receives the request for external review.

The IRO’s notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the claim amount [if available], and the reasons for the previous denials);
- The date the IRO received the external review assignment from CVS Caremark, and the date of the IRO’s decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;
- A discussion of the principal reason(s) for the IRO’s decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the member;
- A statement that the member may still be eligible to seek judicial review of any adverse external review determination; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman available to assist the member.

Reversal of the Plan’s Prior Decision:

If CVS Caremark, acting on the Plan’s behalf, receives notice from the IRO that it has reversed the prior adverse determination of the member’s Claim, CVS Caremark will immediately provide coverage or payment for the Claim.
FEDERAL EXTERNAL REVIEW PROCESS (NON-EXPEDITED)

A member may request an expedited external review if:

- The member receives an Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member, and/or could result in the member’s failure to regain maximum function, and the member has filed a request for an expedited internal appeal; or

- The member receives a Final Internal Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves; (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the member, and/or could result in the member’s failure to regain maximum function.; or (ii) an admission, availability of care, continued stay, or a prescription drug benefit for which the member has received emergency services, but has not been discharged from a facility.

Request for Review:

If the member’s situation meets the definition of urgent under the law, the external review of the Claim will be conducted as expeditiously as possible. In that case, the member or the member’s physician may request an expedited external review by calling the Customer Care toll-free at the number on the member’s benefit ID card or contacting the benefits office. The request should include the member’s name, contact information including mailing address and daytime phone number, member ID number, and a description of the coverage denial.

Alternatively, a request for expedited external review may be faxed. Member contact information, a coverage denial description, and supporting documentation may be faxed to the attention of the CVS Caremark External Review Appeals Department at fax number 1-866-443-1172.

All requests for expedited review must be clearly identified as “urgent” at submission.

Preliminary Review:

Immediately on receipt of a member’s request for expedited external review, CVS Caremark will determine whether the request meets the reviewability requirements described above for standard external review. Immediately upon completing this review, CVS Caremark will notify the member that: (i) the member’s request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.

Referral to IRO:

Upon determining that a member’s request is eligible for expedited external review, CVS Caremark will assign an IRO to review the member’s Claim. CVS Caremark will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Adverse Benefit Determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for external review, the IRO will review the member’s Claim de novo and will not be bound by the decisions or conclusions reached on behalf of the Plan during the internal claims and appeals process.
Timing of the IRO’s Determination:

The IRO must provide the member and CVS Caremark, on behalf of the Plan, with notice of its determination as expeditiously as the member’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the member’s request for external review. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide the member and CVS Caremark, on behalf of the Plan, with written confirmation of its decision.

Authority for Review:

CVS Caremark will be responsible only for conducting the preliminary review of a member’s request for external review, ensuring that the member is timely notified of the decision as to eligibility for external review, and for assigning the request for external review to an IRO.

The actual external review of a member’s appeal will be conducted by the assigned IRO. CVS Caremark is not responsible for the conduct of the external review performed by an IRO.