BlueCross BlueShield of Illinois







Your Health Care Benefits Program

Blue Balance Funded℠
BluePrint℠ PPO

300 East Randolph Street | Chicago, IL 60601-5099

Or call us at the phone number on the back of your identification card.

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.

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 CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE BENEFIT BOOKLET IN NON-EMERGENCY SITUATIONS. Except in limited situations governed by the federal No Suprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), Non-Participating Providers furnishing non-emergency services may bill members for any amount up to the billed charge after the Plan has paid its portion of the bill. If you elect to use a Non-Participating Provider, Plan benefit payments 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 Policy. Participating Providers have agreed to ONLY bill members the cost-sharing 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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Provider Directory	bcbsil.com/find-care/providers-in-your-network/find-a-doctor-or-hospital
Prescription Drug List	bcbsil.com/rx-drugs/drug-lists/drug-lists
Prior Authorization List	bcbsil.com/docs/provider/il/claims/um/2024-ma-pa-codelist.pdf
Preventive Services	bcbsil.com/provider/clinical/clinical-resources/preventive-care
• Customer Service • Prior Authorization • Inpatient Admissions • Appeals • **Claim** Forms • Prescription Drug • Mail-order Services • Pharmacy Locator	See **CUSTOMER SERVICE** section in this benefit booklet for contact information such as phone numbers, websites and mailing addresses where available
Definitions	See **GLOSSARY** section. Defined terms are in bold in your booklet
Your cost share information for **covered services**	See **SUMMARY OF BENEFITS** section. Cost shares for medical and pharmacy services are listed separately in this section.

SUMMARY OF BENEFITS

This is your **SUMMARY OF BENEFITS**. It shows your cost share including **deductible** amounts, **copayment** amounts and **coinsurance** amounts and how they apply to the **covered services** you receive under this **plan**. The information below summarizes your cost share and any limits that may apply to **covered services**. You may contact Customer Service at the telephone number on the back of your member **identification card** for any questions or additional information.

How cost sharing works:

- The **deductible** amounts and **copayment** amounts listed in the charts below show the amounts you pay for **covered services**.
- **Coinsurance** amounts, if any, listed in the charts below are the percentage of the **allowable amount** you pay. You may have to satisfy **deductible** amount(s), **copayment** amount(s) and/or **coinsurance** amount(s) before you receive services.
- All **copayment** and **coinsurance** costs shown in the charts below are after your **deductible** has been met, if a **deductible** applies.
- Your **benefit period** is a period of one year beginning on January 1 of each year. When you first enroll under this plan, your coverage begins on the date shown above and ends on the first day of the month the following year. For example: 01/01/2025 - 01/01/2026.

Benefit Period	Calendar year

Deductible

Deductible	**In-Network Providers**	**Out-of-Network Providers**
Individual	$3,500	$7,000
Family	$10,500	$21,000

- Copays are not usually subject to deductible, but always applied to out-of-pocket maximums.
- If a single-family member reaches the individual deductible then coinsurance will apply and they do not have to wait for other members to meet their deductible
- In-network deductible amounts will not be applied to out-of-network deductible amounts

Out-of-Pocket Maximum

Out-of-Pocket Maximum	**In-Network Providers**	**Out-of-Network Providers**
Individual	$6,000	$18,000
Family	$12,000	$36,000

- Copays are not usually subject to deductible, but always applied to out-of-pocket maximums.
- If a single-family member reaches the individual out-of-pocket maximum then coinsurance will apply and they do not have to wait for other members to meet their out-of-pocket maximum
- In-network out-of-pocket amounts will not be applied to out-of-network out-of-pocket amounts

All limits are combined for **in-network** and **out-of-network benefits** unless stated otherwise.

Acupuncture

Description	**In-Network** **You pay**	**Out-of-Network** **You pay**
Acupuncture	Not Covered	

Allergy Care

Description	In-Network You pay	Out-of-Network You pay
Allergy Injections When billed separately from an office visit	No charge	Covered based on type of service and where it is received

Ambulance Services

Description	In-Network You pay	Out-of-Network You pay
Air Ambulance	20% coinsurance after benefit plan deductible is met	20% coinsurance after benefit plan deductible is met
Ground Ambulance	20% coinsurance after benefit plan deductible is met	20% coinsurance after benefit plan deductible is met
• For out-of-network air ambulance: member shall not be liable for any amount over the in-network cost share. Member will be held harmless if balance billed		

Autism and Autism Spectrum Disorder Services

Description	In-Network You pay	Out-of-Network You pay
Autism and Autism Spectrum Disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Behavioral Health Services (Mental Health and Substance Use Disorder)

Description	In-Network You pay	Out-of-Network You pay
Mental Health Services	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Substance Use Disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Chiropractic Care

Description	In-Network You pay	Out-of-Network You pay
Chiropractic Care	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
Limits	30 visits per calendar year	
• Visit limit does not apply to treatment administered in the patient's home		

Dental Services for Accidental Injury

Description	In-Network You pay	Out-of-Network You pay
Dental Services with Accidental Injury	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met

Durable Medical Equipment (DME)

Description	In-Network You pay	Out-of-Network You pay
DME	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met

Emergency Services

Description	In-Network You pay	Out-of-Network You pay
Facility Charges	$150 copay per visit then No charge	$150 copay per visit then No charge
Physician Charges	No charge	No charge
• Emergency Room copay waived if admitted		

Fertility Services

Description	In-Network You pay	Out-of-Network You pay
Fertility Treatments	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Gender Affirming Care

Description	In-Network You pay	Out-of-Network You pay
Gender Affirming Care	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing Aids and Audiological Services

Description	In-Network You pay	Out-of-Network You pay
Bone Anchored Hearing Aids	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
Hearing Aids	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
Limits	1 hearing aid, per ear, every 24 months	

Home Health Care

Description	In-Network You pay	Out-of-Network You pay
Home Health Care	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met

Hospice Care

Description	In-Network You pay	Out-of-Network You pay
Hospice Services	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
• Non plan providers pay at 50%		

Infusion Therapy

Description	In-Network You pay	Out-of-Network You pay
Performed in the Home, Office or Infusion suite	$50 copay per visit then No charge	40% coinsurance after benefit plan deductible is met
Performed in an Outpatient Hospital Setting	$500 copay per visit then No charge	40% coinsurance after benefit plan deductible is met
• NOTE: Outpatient infusion site of care does NOT apply to HSA products/plans. • Specific targeted outpatient infusion drugs require prior authorization (PA is not dependent on plan design with ISOC benefit differential), before the therapy services are administered. If approved, the SoC benefit will apply. If denied, infusion drugs PLUS infusion therapy services will be denied.		

Inpatient Hospital Services

Description	In-Network You pay	Out-of-Network You pay
Inpatient Facility Services	20% coinsurance after benefit plan deductible is met	$300 per occurrence deductible then 40% coinsurance after benefit plan deductible is met
Inpatient Rehabilitation Services	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
Inpatient Professional/Physician/Surgical Services	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
• Non-plan/non-administrator providers pay at 50% • The per occurrence deductible is in addition to your benefit program deductible.		

Maternity Services

Description	In-Network You pay	Out-of-Network You pay
Physician Office Services, Including Prenatal and Postnatal Care	Same as PCP office visit services for initial visit (per pregnancy)	Same as PCP office visit services for initial visit (per pregnancy)
Diagnostic, Radiology, Ultrasound and Laboratory Procedures	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Physician Services for Delivery	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
Hospital Services	Same as other Hospital Services	Same as other Hospital Services
Maternity for Dependents	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Human Breast Milk for Infants	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Naprapathy Services

Description	In-Network You pay	Out-of-Network You pay
Naprapathy Services	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Benefit Limitation	15 visits per year	
• Visit limitation does not apply to services delivered in the patient's home		

Occupational Therapy Services

Description	In-Network You pay	Out-of-Network You pay
Occupational Therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Orthotic Devices

Description	In-Network You pay	Out-of-Network You pay
Orthopedics/Orthotic Devices	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
Benefit Limitation	Foot orthotics limited to 2 maximum per calendar year	

Outpatient Hospital Facility Services

Description	In-Network You pay	Out-of-Network You pay
Outpatient Facility Services	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
Outpatient Surgical Services & Ambulatory Surgical Facility	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
Outpatient Lab & X-Ray	Physician office visit copay then No charge	40% coinsurance after benefit plan deductible is met
Outpatient Diagnostic & High-Cost Imaging	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
Outpatient Breast MRI	No charge	No charge

- Any applicable copays listed are considered per occurrence deductibles. The per occurrence deductible is in addition to your benefit program deductible.

Pharmacy Services

For information on prescription drugs benefit and cost share please refer to your **SUMMARY OF BENEFITS FOR PHARMACY BENEFITS** directly following this **SUMMARY OF BENEFITS**

Physical Therapy Services

Description	In-Network You pay	Out-of-Network You pay
Physical Therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and Specialist Services

Description	In-Network You pay	Out-of-Network You pay
Primary Care Office Visit	$25 copay per visit then No charge	40% coinsurance after benefit plan deductible is met
Specialty (Specialist) Office Visit	$50 copay per visit then No charge	40% coinsurance after benefit plan deductible is met
Mental Health & Substance Abuse Office Visit	$25 copay per visit then No charge	40% coinsurance after benefit plan deductible is met
Telehealth & Telemedicine Services	$25 copay per visit then No charge	40% coinsurance after benefit plan deductible is met
Virtual Visits	$25 copay per visit then No charge	Not Covered
Other Physician Services	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met

Preventive Care Services

Description	In-Network You pay	Out-of-Network You pay
Preventive Care Services	No charge	40% coinsurance after benefit plan deductible is met

Private Duty Nursing

Description	In-Network You pay	Out-of-Network You pay
Private Duty Nursing	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met

Prosthetic Appliances

Description	In-Network You pay	Out-of-Network You pay
Prosthetic Appliances	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met

Routine Vision

Description	In-Network You pay	Out-of-Network You pay
Routine Vision	Not Covered	
Pediatric Vision	Not Covered	

Skilled Nursing Facility

Description	In-Network You pay	Out-of-Network You pay
Skilled Nursing Facility	20% coinsurance after benefit plan deductible is met	$300 per occurrence deductible then 40% coinsurance after benefit plan deductible is met

- The per occurrence deductible is in addition to your benefit program deductible.
- Non-plan/non-administrator providers pay at 50%

Speech Therapy

Description	In-Network You pay	Out-of-Network You pay
Speech Therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Sterilization Services

Description	In-Network You pay	Out-of-Network You pay
Elective Sterilization	No Cost Share	Covered based on where it is received
Sterilization Reversal	Not Covered	Not Covered

Temporomandibular Joint Dysfunction (TMJ)

Description	In-Network You pay	Out-of-Network You pay
TMJ	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met

Transplant Services (Organ and Tissue Transplants)

Description	In-Network You pay	Out-of-Network You pay
Organ and Tissue Transplants	20% coinsurance after benefit plan deductible is met	$300 copay per stay then 40% coinsurance after benefit plan deductible is met
Covered Associated Procedures	Covered based on type of service and where it is received	
Travel and Lodging	100% up to $50 per day with a lifetime maximum of $10,000 per transplant	
Limits	$10,000 lifetime maximum	

- Meals are not considered a qualified expense under the code unless provided in a hospital or similar facility.
- Any applicable copays listed are considered per occurrence deductibles. The per occurrence deductible is in addition to your benefit program deductible.

Urgent Care

Description	In-Network You pay	Out-of-Network You pay
Urgent Care Center Visit	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met

Weight Loss Services

Description	In-Network You pay	Out-of-Network You pay
Weight Loss Services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Wigs

Description	In-Network You pay	Out-of-Network You pay
Wigs	20% coinsurance after benefit plan deductible is met	40% coinsurance after benefit plan deductible is met
Limits	One wig per benefit period	

SUMMARY OF BENEFITS for PHARMACY BENEFITS

This is your summary of benefits for prescription drugs. It shows your cost share including **deductible** amounts**, copayment** amounts and **coinsurance** amounts and how they apply to the **covered prescription drugs** you receive under this plan. The information below summarizes your cost share and any limits that may apply to prescription drugs. You may contact Customer Service at the telephone number on the back of your member **identification card** or access your self-service online member portal, Blue Access for Members℠ (BAM) for any questions or additional information.

The **PHARMACY BENEFITS** section of this benefit booklet includes details on how the following **pharmacy benefits** work:

- Pharmacy **deductible**
- How **copayment** and/**coinsurance** amounts apply.
- How payment is determined (i.e., what are the tiers).
- **Prior authorizations**
- Limitations and exclusions

Retail Pharmacy Cost Share

Retail Pharmacy Program	Preferred Participating Pharmacy You pay	Non-Preferred Pharmacy You pay	Out-of-Network Retail Pharmacy You pay
Tier 1	$5 copay	$15 copay	50% of eligible charges plus the non-preferred pharmacy copayment and/or coinsurance
Tier 2	$15 copay	$25 copay	50% of eligible charges plus the non-preferred pharmacy copayment and/or coinsurance
Tier 3	$60 copay	$80 copay	50% of eligible charges plus the non-preferred pharmacy copayment and/or coinsurance
Tier 4	$110 copay	$130 copay	50% of eligible charges plus the non-preferred pharmacy copayment and/or coinsurance
Tier 5	$250 copay	$250 copay	50% of eligible charges plus the non-preferred pharmacy copayment and/or coinsurance
Tier 6	$350 copay	$350 copay	50% of eligible charges plus the non-preferred pharmacy copayment and/or coinsurance
• If you receive a brand name drug when a generic drug is available, you may incur additional costs. Refer to the **PHARMACY BENEFITS** section of your benefit booklet for details.			

Extended Prescription Drug Supply Program

Extended Prescription Drug Supply Program	Quantity Dispensed	Participating Extended Supply Pharmacy You pay	Non-Participating Extended Supply Pharmacy You pay
Tier 1	1 to 30 days	$5 copay	Not covered
	31 to 60 days	$10 copay	Not covered
	61 to 90 days	$15 copay	Not covered
Tier 2	1 to 30 days	$15 copay	Not covered
	31 to 60 days	$30 copay	Not covered
	61 to 90 days	$45 copay	Not covered
Tier 3	1 to 30 days	$60 copay	Not covered
	31 to 60 days	$120 copay	Not covered
	61 to 90 days	$180 copay	Not covered
Tier 4	1 to 30 days	$110 copay	Not covered
	31 to 60 days	$220 copay	Not covered
	61 to 90 days	$330 copay	Not covered
• If you receive a brand name drug when a generic drug is available, you may incur additional costs. Refer to the **PHARMACY BENEFITS** section of your benefit booklet for details.			

Mail-Order Pharmacy Program

Mail-Order Pharmacy Program (90-Day Supply)	Participating Mail-Order Pharmacy You pay	Any Pharmacy other than the Participating Mail-Order Pharmacy You pay
Tier 1	$15 copay	Not covered
Tier 2	$45 copay	Not covered
Tier 3	$180 copay	Not covered
Tier 4	$330 copay	Not covered

Specialty Pharmacy Program

Specialty Pharmacy Program (30-Day Supply)	Specialty Network Pharmacy You pay	Any Pharmacy other than a Specialty Network Pharmacy You pay
Tier 5	$250 copay	50% of eligible charges plus the non-preferred pharmacy copayment and/or coinsurance
Tier 6	$350 copay	50% of eligible charges plus the non-preferred pharmacy copayment and/or coinsurance
• One copayment amount per 30 day supply – limited to a 30 day supply.		

- Coverage for specialty drugs is limited to a 30-day supply. However, some specialty drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply, if allowed by your plan benefits.

Vaccines

Select Vaccines Obtained through Pharmacies	Pharmacy Vaccine Network Pharmacy You pay	Other Pharmacy You pay
	Covered vaccine(s) - $0 copay	Not covered

- Vaccinations that are considered preventive care services will not be subject to any **deductible**, **coinsurance**, **copayment** or dollar maximum when such services are received from a **participating provider pharmacy** that is contracted for such service.
- Vaccinations that are received from a **non-participating provider**, a **non-plan provider** facility, or a **non-participating pharmacy** or other routine **covered services** not provided for under this provision may be subject to the **deductible**, **coinsurance**, **copayment** and/or benefit maximum.

Diabetes supplies are available under the **Pharmacy Benefits** portion of this plan.

A separate copayment or coinsurance will be required for both insulin and insulin syringes regardless if they are obtained on the same day. The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $35, when obtained from a participating pharmacy.

Certain covered drugs may be available at no cost through a **participating pharmacy** for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses and nitrates. For further information, call the number on the back of your identification card.

The copayment amount for epinephrine injector twin-packs included in the drug list will not exceed $60. Out-of-network penalties may apply for non-participating and out-of-network pharmacies.

If you have a pharmacy deductible the cost share values listed above will apply after your deductible has been met.

Select **covered drugs**, determined by the **plan**, may be covered with no member cost share, to make these medications more affordable to members.

CUSTOMER SERVICE

Medical Benefits	Call	Fax	Website
Customer Service Helpline	1-800-538-8833	1-866-414-4258	www.bcbsil.com BCBSIL Provider Directory Wellness Other Online Services and Information
Prior Authorization (for Non-Behavioral Health) (for Behavioral Health)	1-877-860-2837	1-800-852-1360	
Inpatient Admissions (for Non-Behavioral Health) (for Behavioral Health)	1-800-572-3089	1-800-852-1360	

Self-Service Member Portal Blue Access For Members (BAM)	**Website**
Provider Directory, Identification Card, Claims	www.bcbsil.com/bcchp/resources/blue-access-for-members

	Fax	**Mailing Address:**
For Medical Appeals Send via fax or mail to	1-866-643-7069	Blue Cross Blue Shield of Illinois Attn: Grievance and Appeals Dept. P.O. Box 660717 Dallas, TX 75266

BLUECARD® NATIONWIDE/WORLDWIDE COVERAGE PROGRAM

1-800-810-BLUE (2583) – http://provider.bcbs.com

MDLIVE®

1-888-684-4233

Prescription Drug Benefits	Call	Fax
Pharmacy Benefit Manager (PBM) Prime Therapeutics Claim Forms and Pharmacy Locator	800-617-5997	877-243-6930

Where to Mail Completed Claim Forms:

For Medical Claims	Prescription Drug Claims
Blue Cross Blue Shield of Illinois Attn: Claims Review Department P.O. Box 660717 Dallas, TX 75266	Prime Therapeutics LLC PO Box 25136 Lehigh Valley, PA 18002-5136

INTRODUCTION

This is your health insurance benefit booklet. It describes your **covered services**, what they are and how you obtain them.

The defined terms throughout this booklet are in bold font and are defined in the **GLOSSARY**.
The terms “you”, “your”, “participant” and “member” are used in this benefit booklet in reference to the **employee** or subscriber.

The terms “we”, “us”, “**claim administrator”**, “BCBS” or the “plan” are used to describe the BlueCross and BlueShield plan that administers your **employer’s** self-funded health plan.

Your **employer** has chosen the **claim administrator**'s participating provider option benefit program for your **hospital** and **physician** benefits that provides you access to the BluePrint network. This program of health care benefits is designed to provide you with economic incentives for receiving **covered services** from a network **provider**.

As a participant in this **benefit** program, a directory of **providers** participating in your network will be available to you. You can visit the BCBS web site at bcbsil.com for a list of participating **providers.** While there may be changes in the network list from time to time, selection of **providers** by BCBS 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 this benefit program will be greater when you receive services from a provider in your network.

In-Network Benefits

To receive your highest level of **benefits** which may be called **in-network** or **participating** as shown under your **SUMMARY OF BENEFITS (SOB)**, you must choose **providers** within the **network** (except for emergencies).

We have established a **network** of **physicians**, **providers**, **specialists**, **hospitals**, and other health care facilities that may offer care and **covered services** to you and your **dependents.** They are listed in our **provider** directory. For help in finding a **provider** in your network you can view our **provider** directory by visiting our website at www.bcbsil.com.

When you choose a **provider** in the network they will bill us, not you, for services provided.

Out-of-Network Benefits

If you choose a **provider** outside of your network which may be referred to as **out-of-network** or non-administrator, this level of **benefit** will be available and therefore paid. You can refer to your **SUMMARY OF**

BENFITS for the specifics of your plan. You may have to pay in full and then submit a **claim** to us for reimbursement when using one of these **providers.**

Your Insurance Identification Card

Show your **identification card** each time you receive services from a **provider**. Your **identification card** will be sent to you. If you haven't received it before you need **covered services**, or if you lose it, you can print a temporary card on the member website at www.bcbsil.com/member. Only members on your plan can use your **identification card**.

About Your Summary of Benefits

Your **SUMMARY OF BENEFITS** shows the out-of-pocket costs you are responsible for when you receive **covered services.** It may also show **benefit** limitations or other useful information that apply to your plan.

Out-of-pocket costs include things like **deductibles**, **copayments** and **coinsurance**. Limitations include things like maximum age, visits, days, hours, and admissions.

Your **SUMMARY OF BENEFITS** will also show any total maximum out-of-pocket limit(s) that may apply.

You are responsible for paying your part of the cost sharing. You are also responsible for costs not covered by us.

See **HOW THE PLAN WORKS** below and your **SUMMARY OF BENEFITS** for more information.

What Medical Necessity/Medically Necessary Means

You will see the terms **medical necessity** or **medically necessary** in your benefit booklet. The **GLOSSARY** defines it but resources like Customer Service or Blue Access for Members℠ (BAM) can get help with questions on if specific services meet the requirements to be considered **medically necessary** or meet **medical necessity**.

Your plan pays for its share of the costs for **covered services** when these requirements are met:

- The service is **medically necessary** and/or meets **medical necessity** requirements.
- For **in-network benefits**, you get the service from a provider in your network.
- Your **provider** or you get **prior authorization** on services when required.

WHO GETS BENEFITS

Eligibility Requirements

The **eligibility date** is the date you or your dependents qualify to be covered under this plan. You are eligible for coverage listed in this benefit booklet when you satisfy the following:

- Meet the definition of an **eligible person** as specified by your **employer.**
- Apply for this coverage.
- Receive a Blue Cross and Blue Shield of Illinois insurance **identification card.**

If you apply for coverage, you may include your eligible dependents. If you have **individual coverage**, only your own expenses for **covered services** are covered, not the expenses of other members of your family.

Dependent Eligibility

Eligible dependents are:

- Your spouse
    - All provisions of this benefit booklet that pertain to a spouse also apply to a party of a **civil union** or **domestic partnership** unless specifically noted otherwise.
    - For the purposes in this benefit booklet all references to and benefits available for **civil unions** also apply to **domestic partnerships.**
- Your child until the month they turn age 26.
- Any other child under 26 years of age such as:
    - A stepchild
    - An eligible foster child
    - An adopted child or child placed for adoption (including a child for whom you or your spouse is a party in a legal action in which the adoption of the child is sought).
- A child who is medically certified as disabled and dependent upon you or your spouse is eligible to continue coverage beyond age 26, provided the disability began before the child turned age 26.

This plan does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.

Note: Civil union and domestic partnership coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **civil union** or **domestic partner** coverage is available under your **plan**.

Applying For Coverage

You and your eligible dependents can apply for coverage during the following time periods by contacting your **employer**:

- During the open enrollment period.
- At special enrollment periods during the year.

Open Enrollment Period

- Your group will designate an open enrollment period during which you may apply for or change coverage for you and your eligible dependents.

Special Enrollment Period

You may apply for or change coverage for yourself and your eligible dependents during the following qualifying events:

- You no longer meet the description of an **eligible person** as specified by your **employer**.
- Your dependent(s) no longer meet the description of an eligible dependent as stated above.
- You or your dependent(s) lose other health insurance coverage or COBRA continuation coverage.
- You gain a dependent through marriage, becoming a party to a **civil union** or court ordered coverage.
- You gain a dependent through birth, adoption, placement for adoption or legal guardianship.
- You or your dependent(s) *lose* eligibility for coverage under Medicaid or Child Health Insurance Program (CHIP).
- You or any of your dependents die.
- You lose coverage under your plan as specified under the **Termination of Coverage** section of this benefit booklet.
- You or your dependent(s) *become* eligible for coverage or premium assistance subsidy under Medicaid or Child Health Insurance Program (CHIP).

You become pregnant, as certified by a qualified **provider**, including a professional midwife. You must request coverage within 60 days of such eligibility.

Late Enrollment

You will be considered a late applicant if your application is not received within the required number of days. You can apply at any time to make those changes. These changes will be effective on a mutually agreed upon date by your **employer** and BCBS.

When Coverage Begins

Coverage begins after you have applied for coverage for yourself and your eligible dependents. The effective date is the date coverage begins. It may be different from the eligibility date.

Dependent Special Enrollment Coverage

Coverage begins from the date of event if you apply for this change within 31 days of any of the following qualifying events. Coverage is automatic for the first 31 days. For coverage to continue beyond this time, you must apply for this change within the 31-day period:

- You gain a dependent through marriage, pregnancy, becoming a party to a **civil union** or court ordered coverage.
    - If a court has ordered you to provide coverage, coverage begins on the first day of the month following the receipt of the application for coverage.
- You or your dependent(s) lose other health insurance coverage or COBRA continuation coverage.

Medicaid or Child Health Plan Special Enrollment Coverage

Coverage begins no later than the first of the month if you apply within 60 days of the following qualifying event:

- You or your dependent(s) *lose* eligibility for coverage under Medicaid or Child Health Insurance Program (CHIP).

- You or your dependent(s) *become* eligible for coverage or premium assistance subsidy under Medicaid or Child Health Insurance Program (CHIP).

Termination of Coverage

Coverage under this plan for you and/or your dependents automatically ends when:

- Your **employer** terminates your coverage.
- The agreement between your **employer** and the **claim administer** is terminated.
- You no longer meet the description of an **eligible person** as specified by your **employer.**
- Your dependent(s) no longer meet the description of an **eligible dependent** as stated above.
- Coverage for you or your dependent(s) will end on the date of the event that made you or your dependents(s) no longer eligible for coverage.
- Coverage for all participants will end if the agreement between your **employe**r and BCBS is terminated.

It is your **employer's** responsibility to notify you if the agreement between your **employer** and BCBS is terminated. Your coverage ends on the termination effective date of the **employer** and BCBS's agreement.

Your coverage terminates on this date regardless of whether your **employer** provides you notice.

Other options available for continuation of coverage are explained in the **COBRA** section of this benefit booklet.

Upon termination of your coverage under the health benefit program, you will be issued a **Certificate of Creditable Coverage (COC)**. You may request a **COC** within 24 months of termination of your or your dependent's coverage administered through this plan by contacting the Customer Service number on the back of your **identification card.**

Your MSP Responsibilities

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

In addition to the GLOSSARY section of this benefit booklet, the following definitions are applicable to this section:

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

a. Health insurance coverage for medical care under any **hospita**l or medical service policy plan, **hospital** or medical service plan contract, or HMO contract offered by a health insurance issuer.
b. A group health plan
c. **Medicare** (Parts A or B of Title XVIII of the Social Security Act)
d. Medicaid (Title XIX of the Social Security Act)
e. Medical care for members and certain former members of the uniformed services and their dependents.
f. A Medical care program of the Indian Health Service or of a tribal organization.
g. A State health **benefits** risk pool.
h. A health plan offered under the Federal Employees Health **Benefits** Program
i. A public health plan established or maintained by a state or any political subdivision of a State, the U.S. government, or a foreign country.
j. A health plan under Section 5(e) of the Peace Corps Act
k. State Children's Health Insurance Program (Title XXI of the Social Security Act)

HOW THE PLAN WORKS

Your **SUMMARY OF BENEFITS** lists what you pay for each type of **covered service**. In general, this is how your **benefits** work:

- You pay the **deductible** when it applies. After your **deductible** amount is paid then your **employer** and you, the participant, share the expense. Your share is called a **copayment (copay)** or a **coinsurance**.
- Then your **employer** via BCBS, the **claim administrator**, pays the entire expense after you reach your **out-of-pocket maximum**.
- Expenses in this general rule means the **allowable amount** for services received from an **in-network provider** or **out-of-network provider**.

Note: Any **provider** who is contracted or participating with BCBSIL may be referred to as **in-network** or participating. Refer to your provider directly for a specific list of providers in your network and the **SUMMARY OF BENEFITS** for their cost shares.

Any provider who does not contract directly with BCBSIL may be referred to as **out-of-network** or **non-administrator**.

Copayments

Some of the care and treatment you receive under the plan will require that a **copay** be paid at the time you receive the services. Refer to the **SUMMARY OF BENEFITS** section of this benefit booklet for your **copayments.**

The following **covered services** are *examples* of services that are not subject to an office visit **copayment**. **Benefits** will be provided at the general payment level shown in the **SUMMARY OF BENEFITS** section of this benefit booklet**.** Services may be subject to **deductible** and or **coinsurance** if applicable:

- Any services provided during the office visit or at the time of consultation (i.e., lab and x-ray services).
- Surgery performed in the **physician's** office.
- Surgery performed in the urgent care center.
- Physical therapy billed separately from an office or urgent care visit.
- Occupational modalities in conjunction with physical therapy.
- Allergy injections billed separately from an office visit.
- Therapeutic injections
- Any services requiring **prior authorization**.
- Certain diagnostic procedures, if shown on your **SUMMARY OF BENEFITS**
- Imaging services, if shown on your **SUMMARY OF BENEFITS**
- Services provided by an independent laboratory, imaging center, radiologist, pathologist, and anesthesiologist.
- Outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

Out-of-Pocket Maximum

The **out-of-pocket maximum** also called the out-of-pocket expense limit is the total amount of **deductibles**, **copayments** and/or **coinsurance** which must be satisfied (paid by you) during a **benefit period** for **covered services.**

How Individual Out-of-Pocket Maximums Work

Once you reach the **out-of-pocket maximum** amount then the **allowable amount** covered by the **plan** will increase to 100% during the remainder of the **benefit period**.

There are separate **out-of-pocket maximums** applicable to **in-network** and **out-of-network providers**.

Refer to your **SUMMARY OF BENEFITS** for amounts for each network level.

How Family Out-of-Pocket Maximums Work

If you have **family coverage** and you reach your **out-of-pocket maximum** for a **benefit** level during one **benefit period**, then, for the rest of the **benefit period**, all other family members will have benefits for **covered services** (except for those **covered services** specifically excluded above) provided at 100% of the **allowable amount** for the **benefit** level whose **out-of-pocket maximum** was reached. Each member may not apply more than the individual **out-of-pocket maximum** toward this amount.

If there is no **out-of-pocket maximum** for **out-of-network providers**, as set forth in the **SUMMARY OF BENEFITS** section of this benefit booklet, you will continue to be responsible for any **deductible**, **coinsurance** and/or **copayments** for **covered services** received from **non-participating pharmacies** and **non-preferred specialty pharmacy providers**.

If a **covered drug** was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by you or on your behalf, that amount will be applied to your program **deductible** or out-of-pocket expense limit.

Deductible(s)

Benefits under your **plan** will be available after you meet your **deductible(s)** as shown in the **SUMMARY OF BENEFITS** section of this benefit booklet.

How individual **deductibles** work:

- **Benefits** such as **coinsurance** will be available to you after your individual benefit plan **deductible** amount or per occurrence **deductible** has been met.

How family **deductibles** work:

- If a single-family member reaches the individual **deductible** shown under your **SUMMARY OF BENEFITS**, they will be eligible for **benefits** and do not have to wait for other family members to meet their **deductible**. This is known as an embedded family deductible.
- In any case, should two or more members of your family ever receive covered services as a result of injuries received in the same accident, only one benefit plan **deductible** will be applied against those **covered services**.

The following are exceptions to the **deductible(s)**:

- People who were **eligible persons** at that time the health benefit program became effective, are entitled to a special credit toward their program **deductible** for the first **benefit period**.
    - This special credit applies to eligible expenses incurred for **covered services** within the prior contract's **benefit period**, if not completed.
    - Such expenses can be applied toward an **in-network** program **deductible** for the first **benefit period** under this health benefit program.
    - This is only true if your health benefit program had “major medical” type coverage immediately prior to purchasing this health benefit program.

If a **covered drug** was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by you or on your behalf, that amount will be applied to your program **deductible** or out-of-pocket expense limit.

Your Benefit Choices

When you need health care, you have the choice of receiving benefits from two types of **providers**:

- A **provider** (**physician** or facility) who has a contract with BCBSIL meaning they have agreed to accept specific prices (**allowable amount**) for services rendered to you.
    - These providers are called **participating providers**, **in-network providers** or **contracted providers**. You will pay the least when you receive services from them.
- A **provider** (**physician** or facility) who does not have a contract with BCBSIL.
    - These providers are called **non-participating**, **out-of-network**, **non-plan** or **non-administrator providers.**

It is important to understand the differences between them.

Before you receive treatment, schedule a surgery or schedule a **hospital** admission, ask each of your **providers** if they are in-network with BCBSIL.

(A **physician’s** or other **provider’s** contract may be separate from the treatment facility’s contract.) Your choice can make a difference in the amount you pay and the **benefits** available to you.

Should you wish to know the **allowable amount** for a specific procedure, or whether a particular **provider** is an **in-network provider**, please contact your professional **provider** or BCBS at the number on the back of your **identification card**.

In-Network Providers

In-network providers have agreed not to bill you for **covered services** for an amount exceeding the **allowable amount.** When you receive **covered services** from an **in-network provider,** you will only be responsible for the difference between the BCBS **benefit** payment and the **allowable amount** for the specific **covered service**. This means your program **deductible**, **copayment** and **coinsurance** amounts.

The **out-of-pocket maximum** for **providers** in your network may be reached by:

- The payments for which you are responsible after **benefits** have been provided (except for any expenses incurred for **covered services** received from non-contracted **providers** other than emergency accident care, emergency medical care during the period of time when your condition is serious).

The **out-of-pocket maximum** will not include:

- The following expenses for **covered services** cannot be applied to the out-of-pocket maximum and will not be paid at 100% of the **allowable amount** when your **out-of-pocket maximum** is reached:
    - Charges that exceed the **allowable amount**.
    - The **coinsurance** resulting from **covered services** received from non-contracted **providers.**
    - Any penalty incurred due to your failure to follow the plan's requirements for **prior authorization.**

Out-of-Network Providers

When you receive **covered services** from an **out-of-network provider**, you are responsible to these **providers** for the difference between the BCBS **benefit** payment and such **provider's** charge to you.

Refer to your **SUMMARY OF BENEFITS** for out-of-pocket amounts for each benefit level. For example, there is no limit on the out-of-pocket expense limit for **covered services** received **from non-plan providers**.

This **out-of-pocket maximum** for non-contracted **providers** may be reached by:

- The payments for **covered services** received from non-contracted **providers** for which you are responsible after **benefits** have been provided.

The **out-of-pocket maximum** will not include:

- The following expenses for **covered services** cannot be applied to the **out-of-pocket maximum** for non-contracted **providers** and will not be paid at 100% of the **allowable amount** when your **out-of-network out-of-pocket maximum** is reached:
    - Charges that exceed the **allowable amount**.
    - The **coinsurance** resulting from **covered services** you may receive from a contracted **provider**.
    - The **coinsurance** resulting from **covered services** rendered by any **provider** or facility that is neither **in-network** nor participating.
    - Charges for **covered services** which have a separate dollar maximum specifically mentioned in benefit booklet.
    - Charges for outpatient prescription drugs
    - Any **copayment**
    - Any penalty incurred due to your failure to follow the **plan's** requirements for **prior authorization.**
    - Any unreimbursed expenses incurred for "comprehensive major medical" **covered services** within your prior contract's benefit period.

Transition of Care Benefits

1. If you are a newly covered person and you are receiving care for a condition that requires **ongoing course of treatment** or if you have entered into the second or third trimester of pregnancy, and your **physician** does not belong to the network, but is within the network's service area, you may request the option of transition of care benefits. Blue Cross and Blue Shield may authorize transition of care benefits for a period up to 90 days from the effective date of enrollment. Authorization of **benefits** is dependent on the **physician's** agreement to contractual requirements and submission of a detailed treatment plan. A written notice of Blue Cross and Blue Shield's determination will be sent to you.

2. If you are a current covered person under the care of a **participating provider** and you are receiving care for a condition that requires **ongoing course of treatment** or if you have entered into the second or third trimester of pregnancy and your **provider** leaves the network, you may request the option of continuity of care benefits as described in the **Continuity of Care** section below.

3. You must submit a written request to Blue Cross and Blue Shield for continuity of care benefits after receiving notification of your **provider's** termination. Blue Cross and Blue Shield may authorize continuity of care benefits for a period up to 90 days from the date of the notice to the covered person of the **provider's** termination from the network. Authorization of benefits is dependent on the **physician**'s agreement to contractual requirements and submission of a detailed plan. A written notice of Blue Cross and Blue Shield's determination will be sent to you.

Continuity of Care

In the event you are under the care of an **in-network**/participating **provider** and the **provider** stops participating in the network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or for fraud), and the **provider** remains within the network service area and agrees to continuing providing coverage at the network rate we will continue providing coverage for you at the **in-network**/participating **benefit** level if you have one of the following special circumstances:

- An **ongoing course of treatment** for a serious acute disease or condition requiring complex ongoing care that you are currently receiving (for example, you are currently receiving chemotherapy, radiation therapy, or post-operative visits for the serious acute disease or condition).
- An **ongoing course of treatment** for a **life-threatening disease or condition** and the likelihood of death is probable unless the course of disease or the condition is interrupted.
- An **ongoing course of treatment** for the second and third trimester of pregnancy through the postpartum period.
- An **ongoing course of treatment** for a health condition of which a treating **provider** attest that discontinuing care by the **participating provider** who is terminated from the network would worsen the conditions or interfere with anticipated outcomes.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than ninety (90) days from the date of the notice to the covered person of the **provider's** disaffiliation from the network, or if the covered person has entered the second or third trimester of the pregnancy at the time of the **provider's** disaffiliation, a period that includes the provision of postpartum care directly related to the delivery. If you are a *newly* covered person whose **provider** is not participating, but is within the network service area, you are able to continue receiving **covered services** with that **provider** at the network **benefit** level to continue an **ongoing course of treatment** as stated above during a transition.

Continuity coverage for a *newly* covered person shall continue until the treatment is complete but will not extend for more than ninety (90) days from the effective date of enrollment, or if the covered person has entered the second or third trimester of pregnancy at the time of the **provider's** disaffiliation, a period that includes the provision of postpartum directly related to the delivery.

Extension of Benefits in Case of Termination

If you are an inpatient at the time your coverage under this health benefit program is terminated, **benefits** will be provided for, and limited to, the **covered services** of this benefit booklet 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.

Federal Balance Billing and Other Protections

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for **plan years** beginning on or after January 1, 2022. Unless otherwise required by federal or Illinois law, if there is a conflict between the terms of this Federal Balance Billing and Other Protections section and the terms in the rest of this certificate, the terms of this section will apply.

COVERED SERVICES

This section describes **covered services** for which your plan pays **benefits** for you and your eligible **dependents. Covered services** must also meet the criteria for **medically necessary**. Some services may require **prior authorization.** It is your responsibility to ensure that **prior authorization** is obtained or those services may carry a cost share penalty or a denial of payment. Refer to the **UTILIZATION MANAGEMENT** section or contact Customer Service by calling the number on the back of your **identification card** or access Blue Access for Members℠ (BAM) for additional information including which services may require **prior authorization**.

Some services may be **covered services** but are not listed in this benefit booklet. For assistance determining if a service will be covered you may call the number on the back of your insurance **identification card**.

Covered services appear alphabetically.

Ambulances Services

Ambulance service 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.

Covered services include:

- Emergency ground transportation by means of a specifically designed and medically equipped vehicle used for transporting the sick and injured.

The following is **not** a **covered service**:

- Long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Transportation provided for the convenience of you, your family/caregivers or physician or the transferring facility.
- Transportation considered not **medically necessary** and is not covered under the health benefit program.

Amino Acid-Based Elemental Formulas

Covered services include:

- 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**.

Autism Spectrum Disorder

Autism spectrum disorder 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.

Covered services include the following when provided by credentialed providers:

- Psychiatric care, including diagnostic services.
- Psychological assessments and treatments
- Habilitative or rehabilitative treatments
- Dental anesthetics as described in the **Dental Services and Anesthesia in a Hospital or Surgery Center** section.
- Therapeutic care, including behavioral speech, occupational and physical therapies that provide treatment in the following areas:
    - Self-care and feeding
    - Pragmatic, receptive, and expressive language
    - Cognitive functioning
    - Applied behavior analysis (ABA) intervention and modification when provided by a qualified ABA provider.
    - Motor planning
    - Sensory processing

Review the **Occupational Therapy**, **Physical Therapy,** and **Speech Therapy** provisions in this benefit booklet for more specific information about how visit maximums for **occupational therapy**, **physical therapy** and **speech therapy** apply to benefits for **Autism Spectrum Disorder(s**).

Behavioral Health Services

Behavioral Health means any condition or disorder involving a mental health condition or substance use disorder listed under any of the diagnostic categories in the mental disorders section of the most recent edition of the International Classification of Disease or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

See the **Mental Health** section of this booklet for additional information on mental health conditions and **substance use disorder**.

The following are **not covered services**:

- Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses or group homes.

Biomarker Testing

Biomarker Testing means the analysis of tissue, blood, or fluid biospecimen for the presence of a biomarker, including, but not limited to, singly-analyte tests, multi-plex panel tests, and partial or whole genome sequencing.

Covered services include:

- **Medically necessary** biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition, including **medically necessary** home saliva cancer screenings, once every twenty-four (24) months, if you are at high risk or showing symptoms of the disease being tested for.

Breast Cancer Screenings and Treatment

See the **PREVENTIVE SERVICES** section of your benefit booklet for additional information in regards to cost share for **covered services** considered preventive.

Covered services include the following when the conditions in this section are met:

- Diagnostic mammograms
- Routine mammograms
- Mastectomy-Related Services
- Inpatient treatment of breast cancer
- Breast cancer pain medication and therapy
- MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when **medically necessary** as determined by a **physician** licensed to practice medicine in all of its branches.
- BRCA1 and BRCA2 genetic testing

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**.

Diagnostic Mammograms

- **Benefits** will be provided when determined to be **medically necessary** by a **physician**, advanced practice nurse or physician assistant.

Routine Mammograms

Routine Mammogram means an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present.

Covered services include the following:

- One baseline mammogram
- An annual mammogram
- If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening and magnetic resonance imaging (MRI) screening of an entire breast or breasts, when determined to be **medically necessary** by your **physician**.

These services may be covered for members who meet the following:

- Have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at the age and intervals considered **medically necessary** by their **physician**.

Mastectomy-Related Services

Covered services include, but are not limited to the following:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- 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.

- Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.
- The removal of breast implants when the removal of the implants is a **medically necessary** treatment for a sickness or injury.
    - Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered **cosmetic surgery**.

The following are **not covered services**:

- Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered.

Benefits for **covered services** related to mastectomies are the same as for any other condition.

Inpatient Hospital Treatment of Breast Cancer

Benefits for **covered services** related to the **treatment of breast cancer** are the same as for any other condition.

Prior authorization is not required for **treatment of breast cancer** for a length of stay less than 48 hours (or 24 hours) for **treatment of breast cancer.** If you require a longer stay called an extension of minimum length of stay, you, your authorized representative, or your **provider** must seek an extension for the additional days by obtaining **prior authorization.**

Your plan is required to provide a minimum length of stay in a **hospital** or facility for the following:

- Treatment of breast cancer:
    - 48 hours following a mastectomy.
    - 96 hours following a lymph node dissection.

Breast Cancer Pain Medication and Therapy

Covered services include:

- All **medically necessary** pain medication and therapy related to the treatment of breast cancer.

Pain therapy means therapy that is medically based and includes reasonably defined goals, including but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

Benefits will also be provided for all **medically necessary** pain medication related to the treatment of breast cancer as described in the **PHARMACY** section of this benefit booklet.

Cardiac Rehabilitation Services

Benefits will be available only 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 trans myocardial revascularization

Chemotherapy

Covered services include:

- Non-self-injected intravenous cancer medications that are used to kill or slow growth of cancerous cells.

Cleft Lip and Palate

Covered services include:

- Medically necessary treatment and care for cleft lip and palate for children under the age of 19.

Clinical Trials

Covered services include:

- **Routine patient costs** and related services you have from a **provider** in communication with participating in an **approved clinical trial**.

The following are **not covered services**:

- The investigational item, device, or service, itself.
- 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.
- A service that is clearly inconsistent with widely accepted and established standards of care for a given diagnosis.

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 recognized under state and/or federal law.

The **approved clinical trial** must be one of the following:

- A federally funded or approved trial.
- A clinical trial conducted under an FDA **experimental/investigational** new drug application.
- A drug that is exempt from the requirement of an FDA **experimental/investigational** new drug application.

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.

Routine Patient Costs means the cost for all covered items and services provided in this benefit booklet that are normally covered for you if you are not enrolled in a clinical trial.

Cosmetic, Reconstructive, or Plastic Surgery

Covered services may include only those that are **medically necessary** for any of the following circumstances:

- Correction of congenital deformities
- Conditions resulting from accidental injuries, scars, tumors or diseases.
- Reconstructive services that are intended to restore physical appearance due to trauma.

The following are **not covered services**:

- Any services, surgery, procedures or supplies solely for cosmetic enhancement reasons.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a physician or other professional provider.

Reconstructive Services means **medically necessary** treatments performed on structures of the body damaged by trauma to restore physical appearance.

For information on mastectomy please see **Breast Cancer Screenings and Treatment**

Dental Services and Anesthesia in a Hospital or Surgery Center

Covered services include:

- Oral surgery (see **Oral Surgery** covered service)
- Dental accident care
- Anesthesia and facility costs for dental care
- Assist at surgery costs.

Anesthesia costs may be covered when:

- Administered at the same time as the covered surgical procedure.
- Administered in connection with dental care treatment if you are:
    - A child is age 6 and under
    - Have a chronic disability.
    - Have a medical condition requiring hospitalization or general anesthesia for dental care.
    - Have been diagnosed with **autism spectrum disorder** or a **developmental disability** and are not yet age 26.

Assist at surgery costs may be covered when:

- Performed by a **physician**, dentist or podiatrist who assists the operating surgeon in performing covered surgery in a **hospital** or ambulatory surgical facility.
- Performed by a registered surgical assistant or an advanced practice nurse.
- Performed by a **physician** assistant under the direct supervision of a **physician**, dentist or podiatrist.

Dental Accident Care means dental services provided by a dentist or **physician**, limited to sound natural teeth, which are required as the result of an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.

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 health diagnosis, 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.
- It results in substantial functional limitations in 3 or more of the following areas of major life activity:
    - Self-care
    - Language
    - Learning
    - Mobility
    - Self-direction
    - The capacity for independent living

Diabetic Equipment, Supplies and Self-Management

Covered services include:

- Outpatient self-management training, education and medical nutrition therapy.
- Education programs that allow you to maintain a hemoglobin A1c level within the range identified in nationally recognized standards of care.
- Regular foot care examinations by a **physician** or Podiatrist.
- Blood glucose monitors for treatment of diabetes (including continuous glucose monitors, non-invasive monitors, and monitors for the blind) for which a **physician** has a written order.

This coverage also includes related supplies, and training in the use of continuous glucose monitors.

Benefits for glucose monitors will be provided at no charge when obtained from a **participating provider**.

Diagnostic Services

Covered services include:

- Tests, scans, and procedures specifically designed to detect and monitor a condition or disease.
- The following are examples of **covered services**:
    - X-ray
    - Pathology services
    - Clinical Laboratory tests
    - Pulmonary function studies
    - Electrocardiograms
    - Electroencephalograms
    - Radioisotope tests

- Electromyograms
- Magnetic resonance imaging (MRI)
- Computed tomography (CT) scans
- Positron emission tomography (PET) scans

The following are **not covered services**:

- **Diagnostic service** as part of:
  - Routine physical examinations or check-ups
  - Premarital examinations
  - Determination of the refractive errors of the eyes
  - Auditory problems
  - Surveys
  - Case finding
  - Research studies
  - Screening, or similar procedures and studies, or tests which are **investigational**, unless otherwise specified in this benefit booklet.

Durable Medical Equipment (DME)

Durable medical equipment also known as (DME) means equipment or supplies ordered by a health care **provider** that help you complete your daily activities, serves a medical purpose and the equipment can withstand repeated daily or extended use.

Covered services include:

- Compression sleeves to prevent or mitigate lymphedema.
- Cardiopulmonary monitors for members age 18 years old and younger.
- The rental and/or purchase of **durable medical equipment (DME)** with a written prescription for your therapeutic use.
  - Rental equipment is not to exceed the total cost of the equipment. If you purchase your durable medical equipment the equipment will only be covered if you need it for long-term use.

The following are examples of covered equipment:

- Internal cardiac valves and pacemakers
- Mandibular reconstruction devices (not used primarily to support dental prosthesis)
- Bone screws, bolts, nails, plates, and other internal and permanent devices
- Wheelchair, cane, crutches, walker, ventilator
- Oxygen and its administration

The following are **not covered services**:

- Modifications to home or vehicle such as: vehicle lifts or star lifts
- Biofeedback equipment
- Computer assisted communication devices.
- Replacement of lost or stolen **durable medical equipment (DME)**

- Personal comfort, hygiene or convenience items such as support garments and air purifiers.
- Physical fitness equipment
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.

Emergency Care

Covered services include:

- Emergency care when rendered for an emergency medical condition.

For information on emergency transportation see **Ambulance Services**.

Emergency Care means health care services provided in a **hospital** emergency facility (emergency room), freestanding emergency medical care facility, or comparable facility to evaluate and stabilize emergency medical conditions.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant member, the health of the member or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or body part
- Inadequately controlled pain
- Regarding a pregnant member having contractions:
    - Inadequate time to complete a safe transfer to another **hospital** before delivery or
    - A transfer to another **hospital** may pose a threat to the health or safety of the member or unborn child.

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.

Mobile Integrated Health Care Services

Covered services include:

- **Medically necessary** health services provided on-site by emergency medical services personnel, when your **provider** has determined such services would likely prevent admission or readmission to a **hospital**, behavioral health facility, acute care facility, or nursing facility.

Family Planning Services

Covered services include the following when the conditions in this section are met:

- Abortion care
- Fertility preservation services
- Infertility treatment
- Oocyte retrievals

- Outpatient contraceptive services

Abortion Care

Your coverage includes benefits for abortion care. Benefits for abortion care will be provided at no cost.

Covered services include:

- Abortifacients
    - Benefits will be provided at no charge for FDA-approved abortifacients including FDA-approved drugs prescribed for off-label use and follow-up services, when obtained from a **participating provider**.

Fertility Preservation Services

Covered services include:

- **Medically necessary** standard fertility preservation services when a necessary medical treatment may directly or indirectly cause Iatrogenic infertility. Coverage for fertility preservation services end when the plan is terminated.
- **Preservation services include:**
    - Embryo cryopreservation
    - Cryopreservation of unfertilized oocytes
    - Storage of covered cryopreserved material
    - For Children: sperm or oocyte cryopreservation for post pubertal children, with patient assent and parent or guardian consent.

Standard fertility preservation services means a procedure upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society for Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

Iatrogenic infertility means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment, affecting reproductive organs or processes.

Hormone Therapies to Treat Menopause

This plan provides **benefits** for **medically necessary** hormonal and non-hormonal treatments for menopausal symptoms, including all FDA approved administration modalities, such as oral, transdermal, topical and vaginal rings.

Infertility Diagnosis and Treatment

Infertility means a disease, condition, or status characterized by:

- The inability to conceive a child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman 35 years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining Infertility).
- A person's inability to reproduce either as a single individual or with a partner without medical intervention; or
- A licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

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:

- 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
- Efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Covered services include:

- Services rendered in connection with the diagnosis and/or treatment of **infertility.**
- These services may include:
    - Uterine embryo lavage
    - Embryo transfer
    - Artificial insemination
    - Oocyte retrievals when the conditions defined in the **Oocyte Retrievals** section below are met.
    - Donor charges, including exam, diagnostic screening, psychological screening as a required.
        - Services may be provided to a third-party as part of the member's infertility treatment, as appropriate.
        - All cost sharing and limitations for services provided to a third-party will apply to the covered individual for whom the infertility is rendered.
- Surgical sperm extraction procedures
- Procedures necessary to screen or diagnose a fertilized egg, before implantation, for aneuploidy, chromosome structural rearrangements, and monogenic or single gene disorders.

Diagnosis and/or treatment of infertility as described above may be covered when the following conditions are met:

1. They are determined to be **medically necessary** by your **provider**, based on clinical guidelines and standards developed by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the Society for Assisted Reproductive Technology; and

2. They are performed at facilities that are members in good standing of the Society for Assisted Reproductive Technology.

The following are **not covered services**:

- Services or supplies rendered to a surrogate including:
    - Non-medical costs of a donor or surrogate including charges incurred to contract with the surrogate.
    - Any other services rendered to a surrogate that are not directly related to treatment of our member's infertility including but not limited to any other services that are a result of the covered infertility procedure/service, i.e. complications, pregnancy check-ups and treatment except that costs for procedures to obtain eggs, sperm, or embryos from you will be covered if you choose to use a surrogate.

- Selected termination of an embryo; provided, however, termination will be covered where the birthing parent's life would be in danger if all embryos were carried to full term.
- Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
    - Benefits may be provided for fertility preservation as set forth in the **Fertility Preservation Services** section.
- Non-medical costs of an egg or sperm donor.
- Travel costs for travel within 100 miles of your home or travel costs **not medically necessary** or required by the **claim administrator**.
- **Infertility treatments** which are deemed **investigational**, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
- **Infertility treatment** rendered to your dependents under age 18.
- Procedures not performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

Oocyte Retrievals

Covered services may include:

- When you have been unable to attain or maintain a viable pregnancy or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments.
    - This requirement will be waived if you or your partner has a medical condition that renders such treatment useless.
- Medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you.
- Associated donor medical expenses including, but not limited to:
    - Physical examinations, laboratory screenings, psychological screenings and prescription drugs

The following apply:

- Benefits for treatments that include oocyte retrievals *are limited to four completed oocyte retrievals per **benefit period***, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered by this health benefit program per **benefit period**.
- If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count as one completed oocyte retrieval.

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.

Covered services include:

- Prescription contraceptive devices, injections, and implants
- Outpatient contraceptive services.

Pregnancy Tests

Covered services include:

- Up to two (2) pregnancy tests every thirty (30) days, when prescribed for at-home use.

Sterilization Procedures (even if they are voluntary)

Benefits for sterilization procedures and follow-up services will not be subject to any deductible, **coinsurance** and/or **copayment** when such services are received from a **participating provider**.

Foot (Podiatric)

Covered services include:

- Examinations and treatment for conditions that affect your feet and lower legs by a physician or podiatrist.

The following are **not covered services**:

- 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.

Gender Affirming Care

Covered services include:

- Gender reassignment and related services, including but not limited to:
    - Diagnostic services
    - Psychological services
    - Hormone therapy
    - Prosthetics
    - Primary sexual characteristic procedures
    - Secondary sexual characteristic (masculinizing or feminizing)
    - Gender reassignment surgeries and related services
    - Reversal of gender reassignment surgical procedures

The following are **not covered services**:

- Gender affirmation treatments which are deemed Experimental/Investigational.

Gender Affirming Care: Those who seek gender-affirming care are often experiencing gender dysphoria, which the APA cites as “psychological distress” stemming from the incongruence between gender assignment and identity. Although many transgender people feel this distress without being diagnosed by a doctor, gender dysphoria is a defined clinical condition in the APA’s Diagnostic and Statistical Manual of Mental Disorders (DSM). The symptoms include “strong” desires to have the primary or secondary sex characteristics of another gender and to be treated as another gender, as well as “significant distress or impairment in social, occupational, or other important areas of functioning.”

Gender Dysphoria: A DSM-5 diagnosis. For a person to be diagnosed with Gender Dysphoria, there must be a marked difference between the individual’s expressed/experienced gender and the gender others would assign them. In children, the desire to be of the other gender must be present and verbalized. This

condition causes clinically significant distress or impairment in social, occupational, or other areas of functioning.

Habilitative Services

Habilitative Services means **occupational therapy**, **physical therapy**, **speech therapy**, and other health care services that help you keep, learn or improve skills and functioning for daily living. They must be prescribed by a physician pursuant to a treatment plan.

Covered services include the following when the conditions in this section are met:

- **Occupational therapy**
- **Physical therapy**
- **Speech therapy**

Habilitative services for **congenital, genetic**, or **early acquired disorder** are covered when the following are true:

- A physician has diagnosed the congenital, genetic, or early acquired disorder.
- Treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, **physician**, licensed nurse, optometrist, licensed nutritionist, clinical social worker, or psychologist upon the referral of a physician.
- Treatment must be **medically necessary** and therapeutic and not **investigational**.

The following is not a **covered service** unless specifically mentioned in this booklet**:**

- Maintenance **occupational therapy**
- Maintenance **physical therapy**
- Maintenance **speech therapy**

Early Acquired Disorder means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self-help skills.

Early acquired disorder may include, but is not limited to:

- Autism or an autism spectrum disorder
- Cerebral palsy

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

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.

Occupational Therapy

Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. **occupational therapy** does not include.

Services may be covered when the following are true:

- Services are rendered by a registered occupational therapist under the supervision of a **physician**.
- Services are furnished under a written plan established by a physician and regularly reviewed by the therapist and physician.
- The written plan was established before treatment began and relates to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

The following is not a **covered service**:

- **Maintenance care**
- Educational training or services designed and adapted to develop a physical function.

If there is a maximum benefit for **occupational therapy**, this maximum will not apply toward, and is not subject to any benefits for autism spectrum disorder(s).

Physical Therapy

Physical Therapy means the treatment of a disease, injury or condition by physical means by a physician or a physical therapist which is designed and adapted to promote the restoration of a useful physical function.

Services may be covered when the following are true:

- A **physician** or physical therapist renders services.
    - When the therapy is beyond the scope of the physical therapist's license the physical therapist must be under the supervision of a physician and the therapy must be furnished under a written plan established by a **physician** and regularly reviewed by the therapist and the **physician**.
- The written 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.

The following is not a **covered service**:

- **Maintenance care**
- Educational training or services designed and adapted to develop a physical function.

If there is a maximum benefit for **physical therapy**, this maximum will not apply toward, and is not subject to any benefits for autism spectrum disorder(s).

Speech Therapy

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.

Services may be covered when the following are true:

- When services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association.
- **Inpatient speech therapy** only if **speech therapy** is not the only reason for admission.

The following is not a **covered service**:

- **Maintenance care**
- Educational training or services designed and adapted to develop a physical function.
- **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.

If there is a maximum benefit for **speech therapy**, this maximum will not apply toward, and is not subject to any benefits for autism spectrum disorder(s).

Hearing Aids

Hearing Aid means any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold.

Covered services include:

- **Medically necessary hearing aids**.
- Related services, such as audiological examinations and selection, fitting, and adjustment of ear molds to maintain optimal fit, batteries and cords will be covered when deemed **medically necessary** by a hearing care professional.
- Hearing aid repairs will be covered when deemed **medically necessary.**
- Bone anchored hearing aids (cochlear implants)

Refer to the **SUMMARY OF BENEFITS** for benefit limitations such as annual maximums.

Home Health Care

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.

Covered services include:

- Home health service visits rendered as part of a Home Care Program and include**:**
    - Professional services of an RN, LPN or LVN
    - Physical, occupational and speech therapists
    - Necessary medical supplies

These services may be covered when you meet the following:

- You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation)
- You must require **skilled nursing service** on an intermittent basis under the direction of your **physician**, a **physician** assistant who has been authorized by a **physician** to prescribe those services, or an advanced practice nurse with a collaborating agreement with a **physician** that delegates that authority.

In addition to those listed above under **Extended Care Services** the following services are not covered:

- Private duty nursing service
- **Custodial care** services
- Services for activities of daily living (personal hygiene, cleaning, cooking, etc.)
- Food or home delivered meals
- Maintenance therapy

Hospice Care 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.

Covered services include:

- The following services rendered as part of a **hospice care program:**
    - Coordinated home care
    - Medical supplies and dressings
    - Medication
    - Nursing services - skilled and non-skilled
    - **Occupational therapy**
    - Pain management services
    - Pediatric palliative care
    - **Physical therapy**
    - Physician visits
    - Social and spiritual services
    - **Respite care service**

The services may be covered when the following are true:

- You must have a terminal illness with a life expectancy of one year or less, as certified by your attending **physician**.
- You will no longer benefit from standard medical care or have chosen to receive **hospice care** rather than standard care.

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.

Examples of these are:

- **Durable medical equipment**
- Traditional medical services provided for the direct care of the terminal illness, disease or condition.

The following services are not covered:

- **Custodial care**
    - 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.
- Home delivered meals.
- Homemaker services
- **Long-term care service**
- **Respite care services** for any service that does not meet the terms of the **Hospice Care Program**.
- Transportation, including, but not limited to, ambulance transportation.

Pediatric Palliative Care means, for children under the age of 21, care focused on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. **Pediatric palliative care** attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person-centered and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness. Through early integration into the care plan for the seriously ill, palliative care improves quality of life for the patient and the family. Palliative care can be offered in all care settings and at any stage in a serious illness through collaboration of many types of care **providers**.

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 can provide such services to you.

Human Immunodeficiency Virus (HIV) Screening and Counseling

Covered services include:

- HIV screening
- Counseling
- Prenatal HIV testing

Services may be covered when they are ordered by a **physician**, **physician** assistant or advanced practice registered nurse who has a written collaborative agreement with a collaborating **physician** that authorizes these services, including but not limited to orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

Inherited Gene Mutation Testing

Covered services include:

- **Outpatient** clinical genetic testing for an inherited gene mutation for those with a personal or family history of cancer, or for evidence-based screenings for those with an inherited mutation, associated with an increased risk of cancer, when recommended by a **provider**.

Cost sharing for this coverage will not exceed $50 per test, when obtained from a **participating provider**.

Inpatient Hospital Services

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

You may be required to get **prior authorization** for an inpatient admission. If the service requires **prior authorization** the following or sooner is recommended:

- Elective admission
    - Call for prior authorization at least 3 days in advance.
- Emergency admission
    - Call for prior authorization within one calendar day of admission.

If a service requires **prior authorization** and you do not obtain it, you may be responsible for a penalty. Refer to your **Summary of Benefits** for this penalty amount.

Covered services include:

- Inpatient care received in a **hospital** setting; this includes:
    - Bed
    - Board
    - General nursing care when you are in a semi-private room, an intensive care unit or a private room.
- Ancillary services such as:
    - Lab work
    - Medical supplies
    - Drugs
    - Operating room
- Preadmission testing as part of your inpatient **hospital** surgical stay provided the following:
    - The tests given to you as an **outpatient** to prepare you for surgery which you are scheduled to have as an inpatient.
    - The benefits would have been available to you had you received these tests as an **inpatient** in a **hospital**.

The following are **not covered services**:

- The inpatient services 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.
- Preadmission testing if you cancel or postpone your surgery.
- Services that are **not medical necessary** such as:
    - **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.
- Inpatient **private duty nursing service**.

Infusion Therapy

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.

Covered services include:

- Infusion services administered by a licensed provider in the following settings:
  - Home
  - Infusion Suite
    - Infusion suite is an alternative to **hospital** and clinic-based infusion setting where specialty medications can be infused.
  - Office
  - Outpatient **hospital**

Some outpatient infusion services for routine **maintenance drugs** have been identified as being safely administered, outside of an outpatient **hospital** setting.

Your out-of-pocket expenses may be lower when **covered services** are provided in an infusion suite, a home, or an office instead of a **hospital**. Refer to your **SUMMARY OF BENEFITS (SOB)** for this information.

Jaw Joint Disorder Treatment (TMJ)

Temporomandibular Joint Dysfunction and Related Disorders means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves and other tissues relating to that joint.

Covered services include:

- The diagnosis, services, supplies and surgical treatment of jaw join disorder by a provider for:
  - Temporomandibular joint dysfunction (TMJ)
  - Myofascial pain dysfunction (MPD)
  - Related jaw disorders

The following are **not covered services** for the treatment of TMJ and all adjacent muscles:

- Non-surgical therapies such as dental restorations, orthodontics, or physical therapy)
- Non-diagnostic services or supplies such as oral appliances, oral splints, oral orthotics, devices or prosthetics.

Maternity Care

Covered services include the following when the conditions in this section are met:

- Human breast milk
- Maternity service

Maternity Service

Maternity Service means the services rendered for normal pregnancy.

Your **benefits** for **maternity services** are the same as your **benefits** for any other condition and are available whether you have **individual coverage** or **family coverage**.

Covered services include:

- Services rendered by a certified nurse-midwife.
- Services received in connection with both normal pregnancy and **complications of pregnancy.**
- Post delivery care and **complications of pregnancy** for dependents.
- Any **hospital** length of stay in connection with childbirth for the birthing parent or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section.
- The following services rendered to your newborn infant even if you have **individual coverage**:
    - Routine inpatient **hospital** nursery charges
    - One routine inpatient examination as long as this examination is rendered by a **physician** other than the **physician** who delivered the child or administered anesthesia during delivery.
    - One Inpatient hearing screening.

If the newborn child needs treatment for an illness, injury, congenital defect (including **medically necessary** treatment of cleft lip and palate), birth abnormalities, and premature birth, **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.

Prior authorization is not required for maternity care unless an extension of minimum length of stay is requested. If you require a longer stay, you, your authorized representative, or your Provider must seek an extension for the additional days by obtaining prior authorization.

Your plan is required to provide a minimum length of stay in a **hospital** or facility for the following:

- Maternity care:
    - 48 hours following an uncomplicated vaginal delivery.
    - 96 hours following an uncomplicated delivery by caesarean section.

Complications of Pregnancy means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

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.

Human Breast Milk

Covered services include:

- Pasteurized donated human breast milk for infants under the age of 6 months which may include human milk fortifiers if indicated when the following conditions are met:
    - A licensed medical practitioner prescribes the milk.
    - The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
    - The infant's birthing parent is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
    - The milk has been determined to be **medically necessary**.
    - One or more of the following applies:
        - The infant's birth weight is below 1,500 grams.
        - The infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
        - The infant has infant hypoglycemia.
        - The infant has congenital heart disease.
        - The infant has had or will have an organ transplant.
        - The infant has sepsis.
        - The infant has any other serious congenital or acquired condition for which the use of donated human breast milk is **medically necessary** and supports the treatment and recovery of the infant.
- Pasteurized donated human breast milk for a child aged 6 -12 months which may include human milk fortifiers if indicated when the following conditions are met:
    - A licensed medical practitioner prescribes the milk.
    - The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
    - The infant's birthing parent is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
    - The milk has been determined to be **medically necessary**.
    - One or more of the following applies:
        - The child has spinal muscular atrophy.
        - The child's birth weight was below 1,500 grams and has long-term feeding or gastrointestinal complications related to prematurity.
        - The child has had or will have an organ transplant.
        - The child has a congenital or acquired condition for which the use of donated human breast milk is **medically necessary** and supports the treatment and recovery of the child.

Medical Benefit Therapeutic Alternatives

Certain prescription drugs administered by a health care professional have therapeutic equivalents or therapeutic alternatives that are used to treat the same condition.

Covered services may be limited to:

- Only certain therapeutic equivalents or therapeutic alternatives. However, benefits may be provided for the therapeutic equivalents or therapeutic alternatives that are not otherwise covered under your benefit, if an exception is granted.
    - To request an exception, you, your prescribing **provider**, or your authorized representative, can call the toll-free telephone number on the back of your **identification card**.

You may contact Customer Service at the toll-free number on the back of your **identification card**, or visit www.bcbsil.com/find-care/medical-rx for more information about covered therapeutic equivalents or therapeutic alternatives.

Therapeutic equivalents or therapeutic alternatives may be covered through your prescription drug benefit, depending on your benefit **plan**.

Outpatient Hospital Care

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.

Covered services include:

- **Surgery** and any related diagnostic service received on the same day as the **surgery**.
    - In addition to surgery performed in a **hospital**, **benefits** will be provided for **outpatient surgery** performed in an ambulatory surgical facility.
- Radiation therapy treatments
- Chemotherapy
- Electroconvulsive therapy
- Renal dialysis treatments
    - If received in a **hospital**, a dialysis facility or in your home under the supervision of a **hospital** or dialysis facility.
- Diagnostic service
    - When you are an **outpatient** and these services are related to **surgery** or medical care
- Urgent care
- Emergency accident care
- Emergency medical care
- Bone mass measurement and osteoporosis
    - Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.
- **Approved clinical trials.**
- Cardiac/pulmonary rehabilitation therapy
    - When provided within six months of a cardiac incident and **outpatient** pulmonary rehabilitation services.

Pediatric Palliative Care

This plan also provides benefits for pediatric palliative care, for children under the age of 21 with a serious illness, by a trained interdisciplinary team that allows a child to receive community-based pediatric palliative care, while continuing to pursue curative treatment and disease-directed therapies for the qualifying illness.

Skilled Nursing Services

Skilled Nursing Service means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical 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.

The following are **covered services** when received in a **skilled nursing facility**:

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

The following are **not covered services**:

- 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.
- Services received in an uncertified skilled nursing facility.
- Service provided due to the lack of willing or available non-professional personnel.
- **Custodial care service**

Tick-Borne Disease

Covered services include:

- Necessary office visits and ongoing testing, for a person with a **tick-borne disease**. Services must be **medically necessary** and ordered by a **physician** after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.
- Drugs when the following are true:
    - An experimental drug if it is approved for an indication by the FDA.
    - A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a **tick-borne disease** if the drug has been approved by the FDA.
    - Long-term oral antibiotics used for the treatment of a **tick-borne disease** unless otherwise provided for in this benefit booklet.

Long Term Antibiotic Therapy means the administration of oral, intramuscular, or intravenous antibiotics singly or in combination for periods of time in excess of 4 weeks.

Tick-Borne Disease means a disease caused when an infected tick bites a person and the tick's saliva transmits an infectious agent (bacteria, viruses, or parasites) that can cause illness, including, but not limited to, the following:

- A severe infection with borrelia burgdorferi.
- A late stage, persistent, or chronic infection or complications related to such an infection.
- An infection with other strains of borrelia or a **tick-borne disease** that is recognized by the United States Centers for Disease Control and Prevention
- With the presence of signs or symptoms compatible with acute infection of borrelia or other **tick-borne diseases**

Mental Health

Mental Health Treatment

Covered services include:

- The treatment of mental health conditions and/or substance use disorders performed in:
    - A **hospital**
    - Psychiatric **hospital**
    - **Residential treatment facility**
- Office visits with a physician, **behavioral health provider**, psychiatrist, psychologist, social worker, or licensed professional counselor
- Partial hospitalization treatment
- **Intensive outpatient program** electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Early treatment of a serious mental illness in a child or young adult under age 26, the following bundled, evidence-based treatment services are covered:
    - Coordinated Specialty Care for First Episode Psychosis (CSC) - benefits for CSC will be covered when provided by FIRST.IL Providers.
    - Assertive Community Treatment (ACT) – benefits for ACT will be covered when provided by DHS-Certified Providers.
    - Community Support Team treatment (CST) – benefits for CST will be covered when provided by DHS-Certified Providers

The following are **not covered services**:

- Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses or group homes.

DHS-Certified Provider means a **provider** certified by the Illinois Department of Human Services' Division of Mental Health and approved to provide services by the Illinois Department of Healthcare and Family Services.

FIRST IL Provider means a provider contracted with the Illinois Department of Human Services' Division of Mental Health.

Intensive Outpatient Program means a freestanding or **hospital**-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat mental health or substance use disorder or specializes in the treatment of co-occurring mental health conditions and substance use disorder.

Requirements: Our **claims administrator** requires that any mental health and/or substance use disorder intensive outpatient program must be licensed in the state where it is located, or accredited by a national organization that is recognized by our **claims administrator**, as set forth in the current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy. **Intensive outpatient program** services may be available with less intensity if you are recovering from severe and/or chronic mental health conditions and/or substance use disorders. If you are recovering from severe and/or chronic mental health conditions and/or substance use disorder, services may include psychotherapy,

pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services. **Intensive outpatient programs** may be used as an initial point of entry into care, as a step up from routine outpatient services, or as a step down from acute inpatient, residential care or a partial hospitalization treatment program.

Mental Illness means a condition or disorder that involves:

- A mental health condition or **substance use disorder** that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
- Any mental health condition that occurs during pregnancy or during the postpartum period, including, but not limited to, postpartum depression. These **benefits** are available for those who have experienced a miscarriage or stillbirth.

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

Organ and Tissue Transplants

Transplant services may be covered for the following organs:

- Cornea
- Kidney
- Bone marrow
- Heart valve
- Muscular-skeletal
- Parathyroid
- Heart
- Lung
- Heart/lung
- Liver
- Pancreas or pancreas/kidney human organ
- Tissue transplants

Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have the **benefits** administered through the Blue Balance Funded℠ program and **claim administrator** coverage each will have their **benefits** paid by their own the **claim administrator program**.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the **benefits** under this 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** under this benefit booklet will be provided for you. However, no **benefits** will be

provided for the recipient.

Benefits will be provided for:

- Inpatient and **outpatient covered services** related to the transplant **surgery**.
- The evaluation, preparation, and delivery of the donor organ.
- The removal of the organ from the donor.
- The transportation of the donor organ to the location of the transplant surgery. **Benefits** will be limited to the transportation of the donor organ in the United States or Canada.

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

- Whenever a heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplant is recommended by your **physician**, you must contact the **claim administrator** by telephone before your transplant **surgery** has been scheduled.
    - The **claim administrator** will furnish you with the names of **hospitals** which have **claim administrator** approved human organ transplant programs.
    - No **benefits** will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any **hospital** that does not have a **claim administrator** approved human organ transplant program.
- Your **benefits** under this coverage will begin no earlier than 5 days prior to the transplant **surgery** and shall continue for a period of no longer than 365 days after the transplant **surgery**. **Benefits** will be provided for all **inpatient** and **outpatient covered services** related to the transplant **surgery**.
- If you are the recipient of the transplant, **benefits** will be provided for transportation and lodging for you and one or two companion(s). 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 lodging will be provided at 100% of the **transplant lodging eligible expense**.
    - **Benefits** for transportation and lodging are limited to a combined lifetime maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.

Covered services also include:

- Immunosuppressant Drugs
    - **Benefits** are available for **medically necessary** immunosuppressant drugs with a written prescription after an approved human organ transplant.

The following are **not covered services**:

- 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 FDA.
    - Storage fees
    - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

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

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**.

Transplant Lodging Eligible Expense means the amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

Orthotic Devices

Covered services include:

- 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.
- Adjustments, repairs or replacement of the device because of a change in your physical condition, as **medically necessary**.
- Custom Orthotics deemed medically necessary (most appropriate model prescribed by a **physician**) for physical activities such as running, biking, swimming, lifting weights, and to maximize whole body health and strengthen the lower and upper limb function.

The following are **not covered services**:

- Repairs and replacements of orthotic devices due to misuse or loss.

Private Duty Nursing

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.

The following are **covered services**:

- Services 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.
- 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.

The following are **not covered services**:

- No **benefits** will be provided when a nurse ordinarily resides in your home or is a member of your immediate family.
- **Benefits** will not be provided due to the lack of willing or available non-professional personnel.
- **Custodial care service**

Prosthetic Appliances

Covered services and supplies include:

- Prosthetic devices
- Special appliances
- Surgical implants
- Prosthetics deemed **medically necessary** (most appropriate model prescribed by a physician) for physical activities such as running, biking, swimming, lifting weights, and to maximize whole body health and strengthen the lower and upper limb function.
- 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** the following:
    - 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.
    - Replacement of cataract lenses when a prescription change is not required.
- One wig per benefit period (also referred to as a cranial prostheses) for hair loss caused by:
    - Chemotherapy
    - Radiation therapy
    - Alopecia

Services and supplies may be covered when:

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

The following are not **covered services**:

- 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.
- Repairs and replacements of prosthetic devices due to misuse or loss.

Surgery

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**.

Additional Surgical Opinion

Covered services include:

- An additional surgical opinion following a recommendation for elective **surgery**.

Benefits for **covered services** are limited to the following:

- One consultation and related diagnostic service by a **physician**.

Benefits for an additional surgical opinion consultation and related diagnostic service will be provided at 100% of the **claim** charge.

Your program **deductible** will not apply to this benefit. If you request, **benefits** will be provided for an additional consultation when the need for **surgery**, in your opinion, is not resolved by the first arranged consultation.

Bariatric Surgery

Covered services include:

- Bariatric **surgery**.

Benefits will be the same as for any other condition.

Breast Reduction Surgery

Covered services include:

- **Medically necessary** breast reduction **surgery**.

Oral Surgery

Covered services include:

- Surgical removal of complete bony impacted teeth
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Surgical procedures to address major injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth, due to accident or disease.
- 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 are **not covered services:**

- Removal of soft tissue or partial bony impacted teeth.

Anesthesia Services

Covered services include:

- 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.
- For anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or ambulatory surgical facility.
- Anesthesia administered in connection with dental care treatment as defined in **Dental Services**

Assist at Surgery

Covered services include:

- Services when performed by a **physician**, dentist or podiatrist who assists the operating surgeon in performing covered surgery in a **hospital** or ambulatory surgical facility.

- Services when performed by a registered surgical assistant or an advanced practice nurse.
- Services when performed by a **physician** assistant under the direct supervision of a **physician**, dentist or podiatrist.

Telehealth and Telemedicine Services

Telehealth and Telemedicine Services means a health care service delivered by a health care professional licensed, certified, or registered to practice in Illinois and acting within the scope of their license, certification, or entitlement to a patient at a different physical location than the health care professional using telecommunications or information technology.

Covered services include:

- **Telehealth and telemedicine services**

Virtual Visits

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 this section and under the **Special Conditions and Payments** section of this benefit booklet.

Covered services include:

- Services described in this benefit booklet for the diagnosis and treatment of non-emergency medical and/or behavioral health injuries or illnesses in situations.
- Only services provided via consultation with a virtual **provider** who has a specific written agreement with BCBS to provide **virtual visits** to you at the time services are rendered.

Services will only be covered when the following is true:

- A **virtual provider** determines that diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit.

The following are **not covered services**:

- Services you receive through an interactive audio or interactive audio/video communication from a **provider** who does not have a specific agreement with the BCBS to provide **virtual visits**.

Note: Not all medical or behavioral health 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.

Virtual Provider means a licensed **provider** who has a written agreement with BCBS to provide diagnosis and treatment of injuries and illnesses through either:

- Interactive audio communication (via telephone or other similar technology)
- 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.

Other Covered Services (Not Referenced Above)

While not all services covered under your plan are listed in this booklet. The following services are covered under your plan when **medically necessary** and performed by duly licensed **providers** are:

- Bone mass measurement and osteoporosis
- Emergency accident care
- Emergency medical care
- Electroconvulsive therapy
- Allergy injections and allergy
- Testing epinephrine injectors
- Radiation therapy treatments
- Tobacco use screening and smoking cessation counseling services
- Massage therapy
- Growth hormone therapy
- Epinephrine injectors
- The processing, transporting, storing, handling and administration of blood and blood components.
- **Covered services** related to fibrocystic breast condition.
- Napropathy services

PREVENTIVE CARE

In addition to the **covered services** in this benefit booklet, all preventive **covered services** will be considered **medically necessary covered services** and will not be subject to any **deductible**, **coinsurance**, **copayment** and/or **benefit** maximum when such services are received from an **in-network provider** or **participating pharmacy.** Preventive care services from **out-of-network providers** may be subject to **deductible**, **copayment** and/or **coinsurance**, except for certain state or federally mandated **benefits** (example: childhood immunizations).

Preventive **covered services** are intended to help keep you healthy, supporting you in achieving your best health through early detection.

The following agencies set the preventive care guidelines:

- United States Preventive Services Task Force ("USPSTF")
- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC")
- Health Resources and Services Administration ("HRSA")
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

The above agencies' recommendations and guidelines may be updated periodically. When updated, they will apply to your plan.

To see a listing of the preventive health services available to you at no cost through an **in-network provider** visit healthcare.gov/coverage/preventive-care-**benefits**/ or call the number on the back of your insurance **identification card**.

For frequencies and any limits that may apply, contact your physician or visit bcbsil.com/provider/clinical/clinical-resources/preventive-care.

Examples of covered preventive services included are:

- Bone density test
- Cancer screening mammograms
- Healthy diet counseling
- Immunizations
- Routine annual physicals
- Obesity screening/counseling
- Preventive cancer screenings
- Screening for colorectal cancer
- Smoking cessation counseling services
- Well-child care
- Contraceptive drugs

Examples of covered immunizations included are:

- Diphtheria
- Haemophilus influenzae type b
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Tetanus
- Varicella
- Any other immunization that is required by law for a child

Preventive Cancer Screening Tests

Benefits for the services listed below will be provided at no charge when received from an in-network provider unless stated otherwise.

Covered services include, but are not limited to:

- Diagnostic and screening mammogram:
    - Routine screening mammogram
    - **Benefits** for diagnostic mammograms will be provided at no charge after your program **deductible** has been met.
    - Refer to section **Breast Cancer Screenings and Treatment** in **COVERED SERVICES** for additional information.
- A diagnostic, medically recognized screening exam for the detection of colorectal cancer for participants who are 45 years of age or older and who are at normal risk for developing colon cancer, and a follow-up colonoscopy if the findings are abnormal.
    - Diagnostic colonoscopies when determined **medically necessary** by a **physician**, APRN, or physician assistant.
- Benefits will be provided for an annual routine prostate cancer screening.
- Annual cervical smear or pap smear test and surveillance tests for ovarian cancer.
- BRCA counseling about genetic testing for members at higher risk and, if recommended by a **provider** after counseling, BRCA genetic testing.
- Routine liver screenings, including liver ultrasounds and alpha-fetoprotein blood tests, for individuals who are at high risk for liver disease, every six months.
- Screening for skin cancer (whole body skin examination for lesions suspicious for skin cancer).

Contraceptive Services

Covered services include:

- Select contraceptive drugs and products shown on the Contraceptive Coverage List which can be found at www.bcbsil.com.
    - See the **PHARMACY BENEFITS** section for additional information.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

1. Any services or supplies that are not **medically necessary**.

2. Any services or supplies determined to be **experimental/investigational** or unproven. You may contact Customer Service at the toll-free telephone number on the back of your **identification card** for more information about what **experimental/investigational** services or supplies may be excluded.

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

4. Any services or supplies provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employment whether or not **benefits** are, or could upon proper **claim** be, provided under the Workers' Compensation law.

5. Any services or supplies provided for injuries sustained either:
   - As a result of war, declared or undeclared, or any act of war.
   - While on active or reserve duty in the armed forces of any country or international authority.

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

7. Any services or supplies that do not meet accepted standards of medical and/or dental care.

8. Any service or supplies by more than one provider on the same day(s) for the same **covered service**.

9. Any services or supplies provided by a person who is related by blood or marriage.

10. Services and supplies to the extent **benefits** are duplicated because the spouse, parent and/or child are covered separately under this health care plan.

11. Services and supplies for the following except as listed as covered in the **COVERED SERVICES** section of your benefit booklet:
    - Any services related to a **non-covered service.**
    - Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes.
    - Dietary and nutritional services
    - 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.
    - Pediatric vision services
    - Immunizations
    - Long term or custodial care

12. 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 a mental health condition. This exclusion 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).

13. Any services or supplies provided for or relating to the following:
    - Hypnotism
    - Blood derivatives which are not classified as drugs in the official formularies.
    - Condoms
    - Self-administered drugs dispensed by a **physician**.

14. Any charges:
    - Resulting from the failure to keep a scheduled visit with a **physician** or other **provider**.
    - For completion of any insurance forms.
    - For acquisition of medical records.
    - Resulting from failure to pay your cost share(s).
    - Incurred while not covered under this plan.
    - For services or supplies you are not required to pay or have no obligation to pay if you did not have this coverage.

15. Any of the following applied behavior analysis (ABA) services
    - Services with a primary diagnosis that is not autism spectrum disorder.
    - Services that are facilitated by a **provider** that is not properly credentialed.
    - Activities primarily of an educational nature.
    - Shadow or companion services
    - Any other services not provided by an appropriately licensed provider in accordance with nationally accepted treatment standards.

16. **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.

17. This plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.

18. Clinical technology, services, procedures, and service paradigms designated by a temporary (CPT® Category III) code are not covered, except for certain services otherwise specified by state or federal law, or federal coverage or billing guidelines.

19. Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy.

PHARMACY BENEFITS

Your plan may not cover all prescription drugs and some coverage may be limited. This does not mean you cannot get prescription drugs that are not covered; you can, but you may have to pay for them yourself. For more information about prescription drug **benefits** see your **prescription SUMMARY OF BENEFITS**. You may also contact customer service by calling the number on the back of your **identification card** or access Blue Access for Members℠ (BAM) for any questions regarding your prescription drug **benefits**.

Although you can go to the **pharmacy** of your choice, your benefit for drugs and supplies will be greater when you purchase them from a **participating pharmacy**. You can visit the **claim administrator**'s website at www.bcbsil.com for a list of **participating pharmacies.** The **pharmacies** that are **participating prescription drug pharmacies** may change from time to time. You should check with your **pharmacy** before purchasing drugs or supplies to make certain of its participation status.

The **benefits** of this section are subject to all of the terms and conditions of this benefit booklet. Please refer to the **GLOSSARY**, **WHO GETS BENEFITS** and **MEDICAL LIMITATIONS AND EXCLUSIONS** sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your **benefits**.

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

Covered Drugs

Benefits for **medically necessary covered drugs** prescribed are available if the drug:

- Has been approved by the FDA for the diagnosis and condition for which it was prescribed.
- Has been approved by the FDA for at least one indication.
- Is recognized by, one of the following for the indication(s) of which the drug is prescribed to treat you for a chronic, disabling or life-threatening illness.
    - A prescription drug reference compendium.
    - Substantially accepted peer-reviewed medical literature.

A separate **copayment** or **coinsurance** amount will apply to each fill of a medication having a unique strength, dosage, or dosage form.

Note: Prescription drugs that are approved by the FDA through the accelerated approval program may be considered **experimental/investigational** and may not be covered.

Abortifacients

Benefits will be provided at no charge for FDA-approved abortifacients, including FDA-approved drugs prescribed for off-label use and follow-up services, when obtained from a **participating provider**.

Blood Glucose Monitors for Treatment of Diabetes

Covered services include:

- **Medically necessary** blood glucose monitors (including continuous glucose monitors, non-invasive monitors, and monitors for the blind, if a **physician** has provided a written order.
- Related supplies, and training in the use of continuous glucose monitors.

Benefits for glucose monitors will be provided at no charge when obtained from a **participating pharmacy**.

Cancer Medications

Covered services include:

- Orally administered or self-injected cancer medications that are used to kill or slow the growth of cancerous cells.

Your **coinsurance** or **deductible** will not apply to orally administered cancer medications when received from a **participating pharmacy**.

Coverage of prescribed orally administered cancer medications when received from a **non-preferred specialty pharmacy provider** or **non-participating pharmacy provider** will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

Contraceptive Drugs

Covered services include:

- Select contraceptive drugs and products shown on the Contraceptive Coverage List

Covered drugs will not be subject to any **deductible**, **coinsurance** and/or **copayment** when received from a **participating pharmacy provider**.

You may access the Contraceptive Coverage List at www.bcbsil.com for more information.

You may also contact the customer service number on the back of your **identification card** to find out if you are responsible for a **copayment**.

Diabetic Supplies for Treatment of Diabetes

Covered services include:

- **Medically necessary** items of diabetic supplies for which a health care practitioner has written an order. Such diabetes supplies shall include, but are not limited to, the following:
    - Test strips specified for use with a corresponding blood glucose monitor.
    - Lancets and lancet devices
    - Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein.
    - Insulin and insulin analog preparations
    - Injection aids, including devices used to assist with insulin injection and needleless systems.
    - Insulin syringes

- Biohazard disposable containers
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels.
- Glucagon emergency kits

A separate **copayment** or **coinsurance** will be required for both insulin and insulin syringes regardless if they are obtained on the same day.

A separate **copayment** or **coinsurance** will be required for both insulin and insulin syringes regardless if they are obtained on the same day. The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $35, when obtained from a **participating pharmacy.**

Fertility Drugs

Covered services include:

- **Medically necessary** fertility drugs in connection with the diagnosis and/or treatment of **infertility** with a written prescription.

Hormonal Therapy for Gender Dysphoria

Benefits will be provided at no charge for FDA-approved hormonal therapy medication for the treatment of gender dysphoria, including FDA-approved drugs prescribed for off-label use, when obtained from a **participating pharmacy**, and for follow-up services, when obtained from a **participating provider**.

HIV Post-Exposure Prophylaxis

Benefits will be provided at no charge for FDA-approved HIV post-exposure prophylaxis drugs, including FDA-approved drugs prescribed for off-label use, when obtained from a **participating pharmacy**, and for follow-up services, when obtained from a **participating provider**.

Injectable Drugs

Covered services include:

- **Medically necessary** injectable drugs which are self-administered that require a written **prescription** by federal law, including but not limited to epinephrine injectors.

The following are **not covered services**:

- Any self-administered drugs dispensed by a **physician**.

Immunosuppressant Drugs

Covered services include:

- **Medically necessary** immunosuppressant drugs with a written prescription after an approved **human organ transplant.**

Long-Term Antibiotic Therapy

Covered services include:

- **Long-term antibiotic therapy**, for a person with a **tick-borne disease,** when determined to be **medically necessary** and ordered by a physician after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.
- Oral antibiotics will be covered under the **PHARMACY** section of this benefit booklet.

- An experimental drug will be covered as a **long-term antibiotic therapy** if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a **tick-borne disease** if the United States Food and Drug Administration has approved the drug.

Opioid Antagonists

Covered services include:

- At least one opioid antagonist drug, including the medication product, administration devices and any **pharmacy** administration fees related to the dispensing of the opioid antagonist.
    - This includes refills for expired or used opioid antagonists.
    - **Note**: **Benefits** for naloxone hydrochloride, will be provided at no charge, when obtained from a **participating pharmacy**.

Pregnancy Tests

Covered services include:

- Up to two (2) pregnancy tests every thirty (30) days, when prescribed for at-home use.

Prenatal Vitamins

Covered Services include:

- Prenatal vitamins, when prescribed by a **physician** or advanced practice nurse.

Prescription Inhalers

Covered services include:

- **Medically necessary** prescribed inhalers for those with asthma or other life-threatening bronchial ailments.

Cost sharing for this coverage will not exceed $25 per 30-day supply, when obtained from a **participating pharmacy**.

Therapies to Treat Menopause

Covered services include:

- **Medically necessary** hormonal and non-hormonal treatments for menopausal symptoms, including all FDA approved administration modalities, such as oral, transdermal, topical, and vaginal rings.

Vaccinations obtained through Participating Pharmacies

Covered services include:

- Select vaccinations administered by certain **participating pharmacies**.
    - For a current listing of vaccines available through this coverage, call Customer Service at the number listed on your **identification card** or visit bcbsil.com/rx-drugs/drug-lists/drug-lists.

The following are **not covered services**:

- Childhood immunizations subject to state regulations.

- Refer to your **claim administrator** medical coverage for **benefits** available for childhood immunizations.

Vaginal Estrogen

Covered services include:

- Medically necessary FDA approved vaginal estrogen (or its therapeutic equivalent).

Specialty Drugs

Benefits are available for **specialty drugs** as described under the **Specialty Pharmacy Program** section.

Benefit Limits

Drug **benefit** limits are designed to help encourage medication use as intended by the FDA. **Benefit** limits are placed on medications in certain drug categories. The **claim administrator** evaluates, and updates **benefit** limits quarterly.

If you require a **prescription** in excess of the dispensing limit established by the **claim administrator**, ask your **provider** to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. If **medically necessary** criteria is not met, you will be responsible for the full cost of the **prescription** beyond what your benefit allows.

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

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

Selecting a Pharmacy

Participating Pharmacy

When you choose to go to a **preferred participating pharmacy** or **participating pharmacy**:

- Present your **identification card** to the pharmacist along with your **prescription**.
- Provide the pharmacist with the birth date and relationship of the patient.
- Pay the applicable **deductible**, if any.
- Pay the appropriate **copayment** for each **prescription** filled or refilled and the pricing difference when it applies to the **covered drug** you receive.
- The difference in cost between the **brand drug** and its generic equivalent will not be applied toward the medical out-of-pocket expense limit and/or the prescription drug out-of-pocket expense limit.
- If a covered prescription drug was paid for by using a drug manufacturer’s coupon or copay card, the coupon/copay card amount will not apply to member’s plan **deductible** and out-of-pocket maximum.

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

- The **billed charges**.
- The **allowable amount**.

- The amount for which you are responsible for as described under the **SUMMARY OF BENEFITS** section of this benefit booklet.

The level of **benefits** paid will be the highest level available under this benefit booklet when pharmaceutical services are received from a **preferred participating provider**.

You may be required to pay for limited or **non**-**covered services**. No **claim** forms are required if you follow the above procedures.

If you are unsure whether a **pharmacy** is a **preferred participating** or **participating pharmacy**, you may access the **claim administrato**r's website at www.bcbsil.com or call the customer service toll-free number on your **identification card**.

Non-Participating Pharmacy

If you choose to have a **prescription** filled at a **non-participating pharmacy**, you must pay the pharmacy the full amount of its bill and submit a **claim** form to the **claim administrator** or to the prescription drug administrator with itemized receipts verifying that the **prescription** was filled. The **claim administrator** will reimburse you for **covered drugs** less:

- The **copayment** amount indicated.
- Less the amount for which you are responsible for as described under the **SUMMARY OF BENEFITS** section of this benefit booklet.
- If a covered prescription drug was paid for by using a drug manufacturer's coupon or copay card, the coupon/copay card amount will not apply to member's plan **deductible** and **out-of-pocket maximum**.

Please refer to the provision entitled **Filing Outpatient Prescription Drug Claims** in the **CLAIM FILING AND APPEALS** section of this benefit booklet.

Extended Prescription Drug Supply Program

Your **benefits** include **benefits** for up to a 90-day supply of maintenance type drugs, **specialty drugs** and diabetic supplies purchased from a **participating prescription drug provider** (which may only include retail pharmacies). Benefit payment amounts are listed in the **SUMMARY OF BENEFITS** section of this benefit booklet.

NOTE: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply

Day Supply

To be eligible for **benefits** under this benefit booklet, the prescribed day supply must be **medically necessary** and must not exceed the maximum day supply limitation described in this benefit booklet.

Some drugs covered under your plan may be subject to certain supply/fill limitations pursuant to diagnosis or new-to-therapy requirements, **plan** design, and/or federal regulations. For specific drug supply/fill information, please call the customer service toll-free number located on your **identification card.**

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

- Coverage for **specialty drugs** are limited to a 30-day supply.
    - Coverage for **specialty drugs** are limited to a 30-day supply. However, some **specialty drugs** have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply, if allowed by your plan **benefits.**

- Early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for **benefits** after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the prescribing **physician** or Optometrist.
    - For additional information about early refills, please see the **Prescription Refills** provision below.

Mail-Order Program

The mail-order program provides delivery of **covered drugs** directly to your home address. In addition to the **benefits** described your **benefits** includes **benefits** for **maintenance drugs** and diabetic supplies obtained through the mail-order program.

Some drugs may not be available through the mail-order program. For a listing of **maintenance drugs** or if you have any questions about the mail-order program, need assistance in determining the amount of your payment, or need to obtain the home delivery order form, you may access the **claim administrator**'s website at www.bcbsil.com or call the customer service toll-free number on your **identification card**. Mail the completed form, your prescription and payment to the address indicated on the form.

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

When you obtain **maintenance drugs** through the mail-order program, **benefits** will be provided according to the mail-order program payment provision described in the **SUMMARY OF BENEFITS** section in the benefit booklet.

For information about the mail-order program, contact your **employer** or group administrator.

Cost-share will be based on the day supply, 1-30 day supply, 31-60 day supply, 61-90 day supply dispensed.

Specialty Pharmacy Program

This program provides delivery of medications directly to your health care practitioner, administration location or to your home if you are undergoing treatment for a complex medical condition. To determine which drugs are **specialty drugs** or to locate a **specialty pharmacy provider**, you should refer to the **drug list** by accessing the **claim administrator's** website at www.bcbsil.com or call the customer service toll-free number on your **identification card**.

The **Specialty Pharmacy Program** delivery service offers:

- Coordination of **benefits** between you, your **provider** and the **claim administrator**.

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

In order to receive maximum **benefits** for **specialty drugs**, you must obtain the **specialty drugs** from the preferred **specialty pharmacy provider**. When you obtain **specialty drugs** from the preferred **specialty pharmacy provider**, **benefits** will be provided according to the payment provisions indicated in this benefit section for a **participating pharmacy**.

Coverage for **specialty drugs** is limited to a 30-day supply. However, some **specialty drugs** have FDA approved dosing regimens exceeding the 30-day supply limited and may be allowed greater than a 30 day-supply, if allowed by your plan benefits. Cost-share will be based on the day supply, 1-30 day supply, 31-60 day supply, 61-90 day supply dispensed.

90-Day Supply Program

The mail-order program provides delivery of **covered drugs** directly to your home address. If you and your covered dependents elect to use the mail-order service, refer to the **SUMMARY OF BENEFITS** section of this benefit booklet.

To receive **benefits** for **maintenance drugs**, you must obtain these medications through the mail-order program or through one of the preferred extended supply pharmacies.

- **Benefits** are available for the original prescription plus one refill at a retail pharmacy for **maintenance drugs**.
- For the third fill of the medication, **benefits** are only available for **maintenance drugs** through the mail-order program or through one of the preferred extended supply pharmacies.
- **Benefits** are not available if you continue to fill your prescription for **maintenance drugs** at a non-extended supply retail pharmacy.

Some drugs may not be available through the mail-order program.

If you have questions about this mail-order program, need assistance in determining the amount of your payment or need to obtain the mail-order prescription form, you may access the website at www.bcbsil.com or contact customer service at the toll-free number on your **identification card**.

Cost-share will be based on the day supply, 1-30 day supply, 31-60 day supply, 61-90 day supply dispensed.

MedsYourWay™

MedsYourWay™ (“MedsYourWay”) may lower your out-of-pocket costs for select **covered drugs** purchased at select in-network retail pharmacies. MedsYourWay is a program that automatically compares available drug discount card prices and prices under your benefit plan for select **covered drugs** and establishes your out-of-pocket cost to the lower price available. At the time you submit or pick up your **prescription**, present your BCBSIL **identification card** to the pharmacist. This will identify you as a participant in MedsYourWay and allow you the lower price available for select **covered drugs.**

The amount you pay for your prescription will be applied, if applicable, to your **deductible** and **out-of-pocket maximum**. Available select **covered drugs** and drug discount card pricing through MedsYourWay may change occasionally. Certain restrictions may apply and certain Covered Drugs or drug discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount for select **covered drugs** depending upon which retail pharmacy is utilized. For additional information regarding MedsYourWay, please contact a customer service representative at the toll-free telephone number on the back of your **identification card.** Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting your Customer Service Representative at the toll-free telephone number on the back of your **identification card.** In the event MedsYourWay fails to provide, or continue to provide, the benefit as stated, there will be no impact to you. In such an event, you will pay the plan's pharmacy benefit **copay**.

Benefit Payment for Prescription Drugs

How Member Payment is Determined

If you or your **provider** request a **brand drug** when a **generic drug** is available, you will pay the applicable **copayment** and/or **coinsurance** based on current tier of **brand drug** plus the difference between the **allowable amount** of the **brand drug** and the **allowable amount** of the **generic drug**, except as otherwise provided in the benefit booklet. Any "differences" between the cost of the **generic drug** and the cost of the **brand drug** will not apply to the **deductible** or **out-of-pocket maximum** and will continue to be applicable after the **out-of-pocket maximum** is met.

You may not be required to pay the difference in cost between the **allowable amount** of the **brand drug** and the **allowable amount** of the **generic drug** if there is a medical reason (e.g., adverse event) you need to take the **brand drug** and certain criteria are met. Your **provider** can submit a request to waive the difference in cost between the **allowable amount** of the **brand drug** and **allowable amount** of the **generic drug.**

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

The amount that you are responsible for is based upon the drug tiers as described below under the **BENEFIT PAYMENT FOR PRESCRIPTION DRUGS** provision in this **PHARMACY BENEFITS** section of this benefit booklet.

- Tier 1 - includes mostly **generic drugs (preferred)** and may contain some **brand drug**s.
- Tier 2 - includes mostly **generic drugs (non-preferred)** and may contain some **brand drug**s.
- Tier 3 - includes mostly **brand (preferred)** and may contain some **generic drugs**.
- Tier 4 - includes mostly **brand drugs (non-preferred)** and may contain some **generic drugs**.
- Tier 5 - includes mostly **specialty drugs (preferred)** and may contain some **generic drugs**.
- Tier 6 - includes mostly **specialty drugs (non-preferred)** and may contain some **generic drugs**.

If you or your **provider** request a **brand drug** when a generic equivalent is available, you will be responsible for the **brand drugs (non-preferred)** payment amount, plus the difference in cost between the **brand drug** and the generic equivalent, except as otherwise provided in this benefit booklet.

To get additional information about your **benefits** for a drug, visit the **claim administrator's** website at www.bcbsil.com and log in to Blue Access for Members (BAM) or call the number on the back of your **identification card**. **Benefits** will be provided as described in the **SUMMARY OF BENEFITS** section of this benefit booklet.

Drug List

In order to be a **covered prescription drug** under this **PHARMACY BENEFITS** section, the **prescription drugs** must be shown on the **drug list**. The drugs on the **drug list** have been selected to provide coverage for a broad range of diseases.

The **drug list** is subject to periodic review and change by BCBSIL. A current list is available website at bcbsil.com/rx-drugs/drug-lists/drug-lists. You may also contact a Customer Service representative at the number shown on your **identification card** for more information.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under this Certificate, will be reviewed by the Pharmacy and Therapeutics Committee and may be added to the applicable **drug list** and be eligible for **benefits** as outlined in the **SUMMARY OF BENEFITS for PHARMACY BENEFITS.**

Oncology Split-Fill Program

If this is your first time using select medications (e.g., cancer medications) or if you have not filled one of these medications recently, you may only be able to receive a partial fill (14-15 day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you.

If you receive a partial fill, your cost-share will be adjusted to align with the number of pills dispensed.

If the medication is working for you and your physician or other **provider** wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply.

For a list of drugs that are included in this program, please visit the bcbsil.com/rx-drugs/pharmacy/programs-other-members program website. Please be advised these lists are subject to change without notice.

Prior Authorization

Prior Authorization (PA)

Your benefit program requires **prior authorization** for certain drugs. This means that your doctor will need to submit a **prior authorization** request for coverage of these medications and the request will need to be approved before the medication will be covered under the plan.

You and your **physician** will be notified of the **prescription** drug administrator's determination. If **medically necessary** criteria is not met, coverage will be denied, and you will be responsible for the full charge incurred.

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

Exceptions

You or your provider can ask for an exception if the drug:

- Is not on (or is being removed from) the **drug list.**
- Requires **prior authorization** before it may be covered.
- The dispensing limit has been found to be (or is likely to be) not right for you or does not work as well in treating your condition.

To request this exception, you, your provider can call the number on the back of your **identification card** to ask for a review.

The **claim administrator** will let you or your provider know the coverage decision within 15 calendar days after they receive your request.

- If the coverage request is denied, the **claim administrator** will let you or your **provider** know why it was denied and offer you a covered alternative drug (if applicable).
- If your exception is denied, you may appeal the decision according to the appeals and external exception review process you receive with the denial determination.

Your request will be reviewed within the required time frames. If you have a health condition that may jeopardize your life, health or keep you from regaining function, you or your **provide**r may be able to ask for an expedited review process.

Expedited Review

In the case of an expedited review the **claim administrator** will let you or your **provider** know the coverage decision within 72 hours after they receive your request.

- If the coverage request is denied, the **claim administrator** will let you or your **provider** know why it was denied and offer you a covered alternative drug (if applicable).
- If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination.

Note: Coverage will be available for a **brand name drug**, if a generic drug or therapeutic equivalent is listed as currently in shortage or as a discontinuation in the FDA drug shortages database.

Controlled Substances Limitations

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

Prescription Refills

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

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

When necessary to permit synchronization, we will prorate the **copayment** amount or **coinsurance** amount, on a daily basis, due for **covered drugs** based on the proportion of days the reduced prescription covers to the regular day supply as described in the **SUMMARY OF BENEFITS** section of this benefit booklet.

Retail Pharmacy

One prescription means up to a 30 consecutive day supply of a drug. Certain drugs may be limited to less than a 30 consecutive day supply. However, for certain **maintenance drugs**, larger quantities may be obtained through the mail-order program. For information on these drugs, contact your **participating pharmacy** or call the customer service toll-free number on your **identification card**. **Benefits** for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Mail-Order Program

One prescription means up to a 90 consecutive day supply of a drug. Certain drugs may be limited to less than a 90 consecutive day supply. For information on these drugs, contact your **participating pharmacy** or call the customer service toll-free number on your **identification card**. **Benefits** for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Specialty Pharmacy Program

In order to receive maximum **benefits** for **specialty drugs**, you must purchase the **specialty drugs** from a **specialty pharmacy provider**. When you purchase **specialty drugs** from a **specialty pharmacy provider**, **benefits** will be provided according to the payment provisions described in the **SUMMARY OF BENEFITS** section of this benefit booklet for **participating prescription drug providers.**

If you obtain **specialty drugs** from a **provider** that is not a **specialty pharmacy provider**, **benefits** will be provided at 50% of the amount you would have received had you obtained drugs from a **specialty pharmacy provider**. When you are responsible for a **copayment**, 50% of the **allowable amount** will be paid minus the **copayment**.

PHARMACY LIMITATIONS AND EXCLUSIONS

Pharmacy benefits are not available for:

1. Drugs/products which are not included on the **drug list**, unless specifically covered elsewhere in in this benefit booklet and/or such coverage is required in accordance with applicable law or regulatory guideline.

2. Non-FDA approved drugs.

3. Drugs which do not by law require a **prescription** from a provider or health care practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs or covered devices for which no valid **prescription** is obtained.

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

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

6. Administration or injection of any drugs.

7. Vitamins (**except** those vitamins which by law require a **prescription** and for which there is no non-prescription alternative).

8. Drugs dispensed in a **physician**'s or health care practitioner's office or during confinement while as a patient in a **hospital**, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

9. **Covered drugs**, devices, or other pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not **benefits** are, or could upon proper **claim** be, provided under the Workers' Compensation law.

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

11. **Covered drugs** for which the pharmacy's usual retail price to the general public is less than or equal to your cost determined under this benefit section.

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

13. Drugs required by law to be labeled: “Caution — Limited by Federal Law to **investigational** Use,” or experimental drugs, even though a charge is made for the drugs.

14. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this benefit section, certain **covered drugs** exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the **physician** or health care practitioner or by law, or any drugs or medicines dispensed. In excess of the amount or beyond the time period allowed to by law.

15. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this benefit booklet. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

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

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

18. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your **employer's** group health care plan, or for which **benefits** have been exhausted.

19. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

20. Compounded drugs that do not meet the definition of **compounded drugs** in this portion of your benefit section or that are determined to be high-risk compounds.

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

22. Prescription for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the **claim administrator**.

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

24. Athletic performance enhancement drugs.

25. Allergy serum and allergy testing materials.

26. Some drugs have therapeutic equivalents/ therapeutic alternatives. In some cases, the **benefits** may be limited to only one of the therapeutic equivalents available. If you do not choose the therapeutic

equivalents that are covered under this benefit section, the drug purchased will not be covered under any benefit level.

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

28. All **brand drugs** in a drug class where there is an over the counter alternative available.

29. Brand-name proton pump inhibitors

30. Compounded drugs

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

32. Devices and pharmaceutical aids

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

34. Surgical supplies

35. Ostomy products

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

37. General anesthetics

38. Bulk powders

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

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

41. Drugs that are not considered **medically necessary** or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

42. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.

43. Any related services to a **non-covered service**. Related services are a) services in preparation for the **non-covered service**; b) services in connection with providing the non-**covered service**; c) hospitalization required to perform the non-**covered service**; or d) services that are usually provided following the **non-covered service**, such as follow up care or therapy after **surgery**.

44. Condoms

45. **Benefits** will not be provided for any self-administered drugs under this section dispensed by a **physician**.

46. Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.

UTILIZATION MANAGEMENT

Utilization management (UM) may be called a **medical necessity** review, utilization review (UR) or medical management. UM is used for a procedure, service, inpatient admission, and/or length of stay and is based on our medical policy and nationally recognized criteria.

If prior authorization is required, the 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 benefit booklet.

Medical necessity reviews may occur:

- Prior to care, before the start of services (**prior authorization**).
- During care (**concurrent review**).
- After care has been completed (**post-service medical necessity review**).

If requested, services normally subject to a **post-service medical necessity review** may be reviewed for **medical necessity** prior to the service through a **recommended clinical review** as defined below.

Please refer to **medical necessity** or **medically necessary** in the **GLOSSARY** section of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your **benefits**.

Note: Any **provider** who is contracted or participating with BCBSIL may be referred to as **in-network** or participating. Refer to your provider directly for a specific list of providers in your network and the **SUMMARY OF BENEFITS** for their cost shares.

Any provider who does not contract directly with BCBSIL may be referred to as **out-of-network** or **non-administrator**.

Prior Authorization

You need pre-approval for some **covered services**. Pre-approval is also called **prior authorization**. This ensures that certain **covered services** will not be denied based on **medical necessity** or as being **experimental/investigational**.

Prior authorization does not guarantee payment of **benefits**. For additional information and a current list of health care services that require **prior authorization**, please visit the BCBS website at www.bcbsil.com.

Prior Authorization Responsibility

In-Network Provider Prior Authorization

When required, your **in-network provider** is responsible for getting **prior authorization**. If your **in-network provider** does not get **prior authorization** and the services are denied as not **medically necessary**, the **in-network provider** will be held responsible.

The **in-network provider** will not be able to bill you for the services you have received. You are encouraged to confirm with your **provider** that **prior authorization** has been obtained.

For additional information about **prior authorization** for services outside of our service area, please refer to the **BlueCard® Program** section.

Note: **Providers** that contract with other Blue Cross and Blue Shield plans are not familiar with the **prior authorization** requirements of BCBSIL. Unless a **provider** contracts directly with BCBSIL the **provider** is not responsible for being aware of this plan's **prior authorization** requirements, except as described in the section the **BlueCard® Program** in **GENERAL PROVISIONS**.

Out-of-Network Prior Authorization

If an **out-of-network provider** recommends an admission or service that requires **prior authorization**, they are not required to get prior authorization for you. **You are responsible for getting prior authorization.**

If the service is found to be **medically necessary**, **out-of-network benefits** will apply. However, if **prior authorization** is not obtained before services are received and determined to be **not medically necessary**, you may be responsible for the charges.

If care is not reasonably available from **in-network providers** as defined by applicable law, and the **claim administrator** authorizes your visit to an **out-of-network provider** to be covered at **the in-network benefit** level prior to the visit then **in-network benefit**s will be paid; otherwise, **out-of-network** benefits will be paid.

Recommended Clinical Review Option

A r**ecommended clinical review** is:

- An optional voluntary **medical necessity** review for a **covered service** that does not require a **prior authorization**.
- Occurs before, during or after services are completed.
- Limits situations where you must pay for a non-approved service.

To determine if a **recommended clinical review** is available for a specific service, please visit our website at www.bcbsil.com/find-care/where-you-go-matters/utilization-management for the **recommended clinical review** list.

Contacting Medical and Behavioral Health

You may contact us for a **prior authorization** or **recommended clinical review** by calling the toll-free telephone number on the back of your **identification card** and following the prompts to the Medical or Behavioral Health Unit or via the member portal.

Additional information on a specific **covered service**s may be available in the **COVERED SERVICES** section of this booklet.

Lack of mention of **prior authorization** for benefits in this booklet does not mean the service does not require **prior authorization**. You or your provider should always contact Customer Service at the number of the back of your **identification card** to determine if **prior authorization** is required.

Post-Service Medical Necessity Review

A **post-service medical necessity review** is sometimes referred to as a retrospective review or **post-service claims request** and determines:

- Your eligibility
- Availability of **benefits** at the time of service.
- **Medical necessity**

Case Management

When you receive **covered services** in an emergency room or are hospitalized for a complex medical situation such as an organ transplant, accident or serious disease, you may be contacted by a case manager.

Case managers are registered nurses (or other health care professionals) who have professional training and clinical experience. They may answer questions about your medical condition, help you understand what to expect when you are discharged from the **hospital** and help coordinate special care you may need.

Medically Necessary Determination

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 **provider**.

The **claim administrator's** determination of **medically necessary** care is limited to merely whether a proposed admission, continued hospitalization, outpatient service or other health care service is **medically necessary** under the plan by using the information available.

If you or your **physician** disagree with the determination of the **claim administrator,** you may appeal that decision or request external review. Information on this process is in the **CLAIM FILING AND APPEALS** section of this benefit booklet.

Medicare Eligible Members

The preadmission review provisions of this **UTILIZATION MANAGEMENT** section do not apply to you if you are **Medicare** eligible and have secondary coverage provided under the health care plan.

CLAIM FILING AND APPEAL PROCEDURES

Filing of Claims Required

When you receive care and **covered services** from a **provider**, the **provider** will usually submit (file) your **claim** directly to us, but it is your responsibility to make sure BCBS receive your **claim. Claims** must filed to the BCBS to get your **benefits**.

When you receive care and **covered services** from an **out-of-network provider**, you may be required to file your own **claim**.

Claims should be filed with the **claim administrator** on or before December 31st of the calendar year following the year in which your **covered service** was rendered.

- For example, if you received the service on 04/01/2024 the **claim** must be filed by 12/31/2025.

Unless your **covered service** was rendered in the last month of the year. In that case it will be considered having happened in the following year.

- For example, if you received the service 12/01/2024 – 12/31/2024 the **claim** must be filed by 12/31/2026.

Claims filed after the time periods listed above will not be considered eligible for payment.

Filing a Medical Claim

Sometimes you may have to file your own **claim**. This may happen when you get care from **providers** other than a **hospital** or physician such as an ambulance.

What	Requirement	Deadline
Complete a **claim** form You can get one from your **employer** or from www.bcbsil.com	Attach copies of all bills to be considered for **benefits**. Bills **must** have: ○ Provider's name and address ○ Patient's name ○ Diagnosis ○ Date of Service ○ Description of the Service (what was done) ○ **Claim** charge	The **claims** must be filed in the same time periods as listed above.
Submit the completed **claim** form	Follow instructions listed on the **claim** form	

Filing An Outpatient Prescription Drug Claim

Sometimes you may have to file your own claim. This may happen for prescription drugs when you either did not receive an **identification card** or you receive **benefits** from a **non-participating prescription drug provider**.

What	How	When
Complete a prescription drug claim form. You can get one from your employer or from www.bcbsil.com	Attach copies of all pharmacy receipts for benefit consideration. Pharmacy receipts **must** be itemized.	**Claims** must be filed no later than one (1) year after the date of service. For example: • A prescription picked up 04/01/2023 must be filed on or before 04/01/2024. • **Claims** filed after the time period listed above will not be considered eligible for payment.
Submit the completed **claim** form	Follow instructions listed on the **claim** form	

Who Receives Payment

Once your **claim** is processed payments will usually be made to the following:

- The **provider** if they filed the **claim**.
- You or your authorized representative if you filed the **claim** and already paid the **provider**.
- For Qualified Medical Child Support Orders (QMSCO) the payment will be made to the designated representative as it appears on the **claim administrator's** records.

(For information regarding assigning **benefits**, see **Payment of Claims and Assignment of Benefits** provisions in the **GENERAL PROVISIONS** section of this benefit booklet.)

Review of Claim Determinations

Claim Determinations

When BCBS receives a properly filed **claim**, it has the authority and discretion under the **plan** to interpret and determine **benefits** in accordance with the **plan's** provisions.

Timing of Required Notices and Extensions

Refer to the **Timing of Required Notices and Extensions Chart - Claims** at the end of this section for specific time frames.

There are four types of **claims** as defined below:

- **Urgent care clinical claim** means any pre-service **claim** that requires **prior authorization**. If it is for medical care of treatment and your **physician** determines that a delay in getting medical care or treatment could put your life or health at risk; or delay might put your ability to regain maximum

function at risk. It could also be a situation in which you need care to avoid severe pain that cannot be adequately managed without the care or treatment.

For **urgent care clinical claims**, you should call the **claim administrator** (at the toll-free number listed on the back of your **identification card**) as soon as possible. You do not need to submit **urgent care clinical claims** in writing.

- **Pre-Service Claim** means any non-urgent request for **benefits** that involves services you have not yet received and requires **prior authorization**.

- **Post-Service Claim** means notification in a form acceptable to us that a service has been rendered or furnished to you.

  This notification must include full details of the service received, including:
  - Your name, age and gender
  - Identification number
  - Name and address of the **provider**
  - An itemized statement of the service rendered or furnished.
  - Date of service
  - Diagnosis
  - **Claim** charge
  - Any other information which we may request in connection with services rendered to you.

- **Concurrent Care Claim** means a **claim** occurs when you need the **claim administrator** to approve more services than we already have approved. Examples are extending a **hospital** stay or adding visits to a **provider**.

BCBS must notify you of the **claim** determination (whether adverse or not).

If a Claim Is Denied or Not Paid in Full

If a **claim** is denied in whole or in part, you will receive a written notice with the following information, if applicable:

- Reasons for the determination.
- A reference to the benefit plan provisions or the contractual, administrative, medical policy or protocol basis for the determination.
- A description of additional information necessary and an explanation of why it is necessary.
- Subject to privacy laws and other restrictions, if any:
  - Identification of the **claim**
  - Date of service
  - Health care **provider**
  - **Claim** amount (if applicable)
  - Statement describing denial codes with their meanings and standards used.
  - Diagnosis/treatment codes with their meanings and the standards used (upon receipt)
- An explanation of BCBS' internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal.

- A statement in non-English language(s) that written notice of **claim** denials and certain other benefit information may be available (upon request) in such non-English language(s) (in certain situations).
- A statement in non-English language(s) that indicates how to access the language services provided by BCBS (in certain situations).
- Copies of all documents, records, and other information relevant to the **claim** (provided free of charge on request).
- Copy of rule, guideline, protocol or other similar criterion (provided free of charge on request).
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances.
- In the case of urgent care clinical **claims**:
    - Description of the expedited review procedure applicable.
    - Decision may be provided orally, so long as a written notice is given to the claimant within 3 days of verbal notification.
    - Contact information for any applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions Chart - Claims

Type of Notice (Claim) or Extension	Time Period
Urgent Care Clinical Claims	
If your **claim** is incomplete, the **claim administrator** must notify you within:	24 hours
If you are notified that your **claim** is incomplete, you must then provide completed **claim** information to the **claim administrator** within:	48 hours after receiving notice
If the initial **claim** is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
• Urgent care clinical **claim** appeals do not need to be submitted in writing. • 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 written notification is requested.	

Pre-Service Claims	
If your **claim** is filed improperly, the **claim administrator** must notify you within:	5 days Notification may be oral unless the claimant requests written notification
If your **claim** is incomplete, the **claim administrator** must notify you within:	15 days
If you are notified that your **claim** is incomplete, you must then provide completed **claim** information to the **claim administrator** within:	45 days after receiving notice
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

Post-Service Claims	
If your **claim** is incomplete, the **claim administrator** must notify you within:	30 days
If you are notified that your **claim** is incomplete, you must then provide completed **claim** information to the **claim administrator** within:	45 days after receiving notice
If the initial **claim** is complete, within:	30 days*
After receiving the completed **claim** (if the initial **claim** is incomplete), within:	45 days

- For both pre-service and post-service **claims** when the initial **claim** is complete the time period may be extended one time by the **claim administrator** for up to 15 days.

- To extend these time periods the **claim administrator** must:

  (1) Determine that such an extension is necessary due to matters beyond the control of the **claim administrator** and

  (2) Notify you, prior to the expiration of the initial time period, of the circumstances requiring the extension of time. Notification must include the date by which the **claim administrator** expects to render a decision.

Concurrent Care Claim	
We will notify you of our determination for such a request within:	**24 hours after receipt of your claim for benefits**

Claim Appeal Procedures

Claim Appeal Procedures and Definitions

Adverse Benefit Determination means the determination that the health care services you have received, or may receive are:

- **Experimental/ investigational**
- Not **medically necessary** or appropriate

An adverse determination includes a denial, reduction, or termination of a benefit, a **pre-service claim**, **urgent care clinical claim**, and a benefit resulting from a utilization review, treatment previously approved being reduced or terminated, or not paying (in whole or in part) for a **benefit** or **claim**.

Expedited Clinical Appeals

Expedited Clinical Appeal means an appeal of a clinically urgent nature related to a denial of health care services, including, but not limited to:

- Procedures or treatments ordered by a **provider**.
- Emergency care
- Continued hospitalization
- If you were receiving prescription drugs or intravenous infusions and coverage was discontinued

If your situation meets the definition of an expedited clinical appeal, you may be able to appeal the decision on an expedited basis.

Appeal Process	Time Period
Prior to an authorization for a current course of treatment or continued hospitalization is terminated or reduced, we will send you a notice giving you an opportunity to appeal.	During the review process, coverage for the ongoing course of treatment will continue.
Concurrent clinical appeal or Pre-service appeal	Within 24 hours of the appeal's receipt, we will tell you if more information is needed to complete our review. Within 24 to 72 hours, depending on the immediacy of the condition, we will let you know our decision.

How to Appeal an Adverse Benefit Determination

You have the right to appeal the following:

- **Claim** determination.
- **Prior authorization** request determination
- Any other determination made by the **claim administrator** in accordance with the rules of your **plan.**

Adverse benefit determination appeals may be submitted by:

- A **provider** on their own behalf.

- You or your authorized representative on your behalf. You must submit your designation of a representative in writing on an **authorized representative form**.

  You can get an authorized representative form by contacting the **claim administrator**. In urgent situations a doctor may act as your authorized representative without completing the form.
- To contact the **claim administrator** to request a **claim** review or appeal an adverse benefit determination, use the following address. Phone and fax numbers can be found in the Customer Service section of this booklet.

Blue Cross and Blue Shield of Illinois
Attn: Claim Review Dept
P. O. Box 660717
Dallas, Texas 75266

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**.

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 procedures.

Appeal Process	Time Period
You may present evidence and testimony in support of your **claim**.	Within 180 calendar days or during the review process
You may review your **claim** file and relevant documents. You may submit written issues, comments, and additional medical information.	Within 180 calendar days or during the review process
We will give you any new or additional information we use to review your **claim** before the date a final decision on the appeal is made. To allow you an opportunity to respond before the final determination is made.	Within 180 calendar days or during the review process
The review and decision of your appeal will be made by personnel not involved in making the initial adverse decision.	During the review process
If the initial adverse decision was based on a medical result, the review will be made by a **physician** associated or contracted with us, and/or by external advisors, who were not involved in the initial Adverse Benefit Determination.	During the review process
Non-urgent concurrent or **pre-service appeal**, within	30 days upon receipt of the appeal
Non-urgent **post-service appeal**, within	60 days upon receipt of the appeal

Notice of Appeal Determination

The BCBS as the **claim administrator** will provide you a written notice of our appeal determination. If your appeal is a **clinical appeal**, the health care **provider** who recommended the services involved will receive the appeal determination.

- The written notice to you or your authorized representative will include:
  - The reason for the determination, including the guidelines used in denying the **claim.**
  - A discussion of the decision.
  - Benefit plan provisions, contractual, administrative, or procedure on which it is based.

- The identification of the **claim,** date of service, health care provider, **claim** amount (if applicable), and a statement describing denial codes with their meanings and the standards used – subject to privacy laws and other restrictions, if any. Upon request, diagnosis/treatment codes with their meanings and the standards used.

- An explanation of the external review process (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a)of ERISA following a final denial on internal review.

- If available, and upon request, a document in non-English language(s)showing how to access the language services, including a written notice of **claim** denials and certain other benefit information.

- The right to request, free of charge, reasonable access to and copies of all documents, records and other information related to **claim** for **benefits**.

- Any internal rule, guideline, procedure, or other similar reasons relied upon in the determination, and instructions on getting a copy of these, upon request, without any cost to you.

- An explanation of the scientific or clinical decision relied upon in the determination, or instructions on getting a copy of the explanation, upon request, without any cost to you.

- Health Insurance Consumer Assistance or Ombudsman contact information (as appropriate).

If your appeal is denied or partially denied, or you do not receive a timely decision, you may request an external review of your **claim** by an independent third party. This independent third party will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** section below.

If You Need Assistance

If you need assistance with the internal **claims** and appeals or the external review processes, you may 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).

Standard External Review

You or your authorized representative 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).

Request for external review

You or your authorized representative must file a request for a standard external review within four months after the date of receipt of notice (or 48 hours following the receipt of the notice), whichever is later, to perfect your request. If your **claim** is not eligible for external review the **claim administrator** will provide the following in your notice:

- Outline ineligibility reasons.
- Provide the Department of Labor's Employee **Benefits** Security Administration (toll-free number 1-866-444-EBSA (3272)).

An external review is available for **adverse benefit determinations** and **final adverse benefit determinations** that involve medical judgment including, but not limited to:

- Requirements for **medical necessity**, appropriateness, health care setting and level of care.
- Effectiveness of covered benefit.
- Determinations that a treatment was **experimental/investigational.**
- Determinations you are eligible to a reasonable alternative standard for a reward under a wellness program.
- Determination of compliance with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act.

Preliminary review

You will be notified within one business day after the preliminary review is completed if your request is eligible or if additional information is needed. The **claim administrator** must complete a preliminary review within five business days of request receipt to determine whether:

- You are, or were, covered under the plan at the time the health care item or service was requested.
- The **adverse benefit determination** or the **final adverse internal benefit determination** does not relate to you not meeting the requirements for eligibility under the terms of the **plan** (e.g., worker classification or similar determinations).
- 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.
- You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within one 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 four-month external review request period (or 48 hours following receipt of the notice), whichever is later, to perfect the request for external review. 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 1-866-444-EBSA (3272)).

Referral to Independent Review Organization (IRO)

When an eligible request for external review is completed within the time period allowed, the **claim administrator** will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the **claim administrator** will ensure that the IRO is unbiased and independent. Accordingly, the **claim administrator** must contract with at least three IROs for assignments under the plan and rotate **claims** assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of **benefits**.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the plan.

- 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 10 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.

- Within five 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 one business day after making the decision, the IRO must notify the **claim administrator** and you or your authorized representative.

- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the **claim administrator**. Upon receipt of any such information, the **claim administrator** may reconsider the 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 the adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one 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**.

- 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. 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:
    - Your medical records.

- The attending health care professional's recommendation.
- Reports from appropriate health care professionals and other documents submitted by the **claim administrator**, you, or your treating provider.
- 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.
- 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.
- 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.
- 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.

- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the **claim administrator** and you or your authorized representative.

- The notice of final external review decision 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 applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial).
  - The date the IRO received the assignment to conduct the external review and the date of the IRO decision.
  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
  - 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.
  - 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** or you or your authorized representative.
  - A statement that judicial review may be available to you or your authorized representative.
  - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

- 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.

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** must immediately provide coverage or payment (including immediately authorizing or immediately paying **benefits**) for the **claim**.

Expedited External Review

Request for Expedited External Review

You may request an expedited external review when you receive:

- An **adverse benefit determination**, if it involves a medical condition 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

- 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.

Preliminary Review

Immediately upon receipt of the request for expedited external review, the **claim administrator** must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. The **claims administrator** must immediately send you a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** section above.

Referral to Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the **claims administrator** will assign an IRO pursuant to the requirements set forth in the **Standard External Review** section above. The **claims 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 **claims administrator's** internal **claims** and appeals process.

Notice of Final External Review Decision

The **claims 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 **claims 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 **claims administrator** waives the internal review process or the **claims 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 **claims 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.

Interpretation of Employer's Plan Provisions

The plan administrator has given the **claims administrator** the initial authority to establish or construe the terms and conditions of the health benefit plan and the discretion to interpret and determine **benefits** in accordance with the health benefit plan's provisions.

The plan administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the health benefit plan.

All powers to be exercised by the **claims administrator** or the plan administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

The **claims administrator** has established the following process to review your dissatisfactions, complaints and/or appeals. If you have designated an authorized representative, that person may act on your behalf in the appeal process.

If you have a question or complaint, an initial attempt should be made to resolve the problem by directly communicating with a BCBSIL customer service representative. In most cases, a customer service representative will be able to provide you with a satisfactory solution to your problem. However, if a resolution cannot be reached in an informal exchange, you may request an administrative review of the problem through our appeal process described below.

You may request to review information used to make any adverse determination. Copies will be provided free of charge.

GENERAL PROVISIONS

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.**
- Pay **administrator providers** substantially less than their **claim** charges for services, by discount or otherwise.
- 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** payable by you as described in this benefit booklet shall be based on the **allowable amount** 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 service**s 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**, and whether you have reached any out-of-pocket or benefit maximums, the **hospital's allowable amount** 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**, 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.

The **claim administrator** or its subsidiaries or affiliates may also have ownership interests in or financial arrangements with certain **providers** who provide **covered services** to covered persons and/or vendors or other third parties who provide services related to the Policy or provide services to certain **providers**.

Inter-Plan Arrangements

Out-of-Area Services

Overview

The **claim administrator** has a variety of relationships with other Blue Cross and Blue Shield Licensees.

Generally, these relationships are call the “Inter-Plan" arrangements. These Inter-plan Arrangements work based on the rules and procedures issued by the Blue Cross Blue Shield Association (“Association"). Whenever you access healthcare services outside the geographic area the **claim administrator** serves the **claim** for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside the **claim administrator's** service area, you will receive it from one or two kinds or **providers**. Most **providers** (“**participating providers**") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue"). Some **providers** (“**non-participating providers**") do not contract with the Host Blue. The **claim administrator** explains below how the **claim administrator** pays both kinds of **providers**.

Inter-Plan Arrangement Eligibility - Claim Types

All **claim** types are eligible to be processed through inter-plan arrangement, as described above, except for all dental care **benefits** except when paid as medical **claims/benefits**, and those **prescription** drug **benefits** or vision care **benefits** that may be administered by a third party contracted by the **claim administrator** to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive **covered services** within the geographic area served by a Host Blue, the **claim administrator** will remain responsible for doing what we agreed to do in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating **providers**.

For inpatient facility services received in a **hospital**, the Host Blue's participating **provider** is required to obtain **prior authorization**. If **prior authorization** is not obtained, the participating **provider** will be

sanctioned based on the Host Blue's contractual agreement with the **provider**, and the member will be held harmless for the **provider** sanction.

Whenever you receive **covered services** outside the **claim administrator**'s service area and the **claim** is processed through the BlueCard Program, the amount you pay for **covered services** is calculated based on the lower of:

- The **billed charge**s for **covered services**
- The negotiated price that the Host Blue makes available to the **claim administrator.**

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

1. 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**.
2. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.
3. The Host Blue, in turn, forwards the **claim** to 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**.
4. So, for example, if your **coinsurance** is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a **covered service**.

Please Note: The **coinsurance** percentage in the above example is for illustration purposes only. The example assumes that you have met your **deductible** and that there are no **copayment**s 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.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive **covered services** under a **value-based program** inside a Host Blue's service are, you will not be responsible for paying any of the Provider incentives, risk-sharing, and/or care coordinator fees that are part of such an arrangement, except when a Host Blue passes these free to the **claim administrator** through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (Non-BlueCard Program Arrangements)

If the **claim administrator** has entered into a negotiated arrangement with a Host Blue to provide **value-based programs** to your **employer** on your behalf, the **claim administrator** will follow the same procedures for **value-based program** administration and care coordinator fees as noted above for the BlueCard program.

Inter-Plan Program: Federal/State Taxes/Surcharges/Fees

Federal or state law or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the **claim administrator** will include any such surcharge tax or other fee as part of the **claim** charge passed on to you.

Non-Participating Healthcare Providers Outside the Claim Administrator's Service Area

Member Liability Calculation

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 health benefit program 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.

Exceptions: In some exception cases, the **claim administrator** may, but is not required to, negotiate a payment with such **non-participating provider** on an exception basis. If a negotiated payment is not available, then the **claim administrator** may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the health benefit program for non-participating **providers** located inside our service area (and described in above) or
2. The following:
    a. 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
    b. 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.

Blue Cross Blue Shield Global Core

If you are outside the United States the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of service center when accessing **covered services**. The service center is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the service center 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/**deductible**s, **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 **prior authorization** for non-emergency Inpatient services.

Outpatient Services

Outpatient services are available for emergency care, **physicians**, urgent care centers and other outpatient **providers** located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a **claim** to obtain reimbursement for **covered services**.

Submitting a Blue Cross Blue Shield Global Core **claim**: When you pay for **covered services** outside the BlueCard service area, you must submit a **claim** to obtain reimbursement. For institutional and professional **claims,** you should complete a Blue Cross Blue Shield Global Core International **claim** form and send the **claim** form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate **claims** processing. Following the instructions on the **claim** form will help ensure timely processing of your **claim**. The **claim** form is available from the **claim administrator**, the service center or online at www.bcbsglobalcore.com. If you need assistance with your **claim** submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Claim Administrator's Separate Financial Arrangements with Prescription Drug Providers

The **claim administrator** hereby informs you that it has contracts, either directly or indirectly, with **prescription** drug providers ("**participating prescription drug providers**") to provide **prescription** drug services to all persons entitled to prescription drug **benefits** under health policies and contracts to which the **claim administrator** is a party, including all persons covered under this health care plan. Under its contracts with participating **prescription drug providers**, the **claim administrator** may receive from these **providers** discounts for **prescription** drugs dispensed to you. Actual discounts used to calculate your share of the cost of **prescription** drugs will vary. Some discounts are currently based on **average wholesale price** ("**AWP**") which is determined by a third party and is subject to change. You understand that the **claim administrator** may receive such discounts. Neither the **employer** nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

Coinsurance amounts payable by you under this health care plan will be calculated on the basis of the provider's **allowable amount** or the agreed upon cost between the **participating prescription drug provider** and the **claim administrator** for a **prescription** drug, whichever is lower.

To help you understand how the **claim administrator's** separate financial arrangements with **prescription** drug providers work, please consider the following example:

a. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is $100. How is the $100 bill paid?
b. You personally will have to pay the **coinsurance** amount set out in this benefit booklet.
c. However, for purposes of calculating your **coinsurance** amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 prescription drug bill would be reduced by 20% to $80 for purposes of calculating your **coinsurance** amount.
d. In our example, if your **coinsurance** obligation is 25%, you personally will have to pay 25% of $80, or $20. You should note that your 25% **coinsurance** is based upon the discounted amount of the prescription and not the full $100 bill.

For the mail-order pharmacy and specialty pharmacy program partially owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail-order pharmacy and/or specialty pharmacy program. The **claim administrator** pays a fee to Prime for **pharmacy benefit** services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, **claims** processing, customer service response, and mail-order processing.

“Weighted Paid **Claim**” refers to the methodology of counting **claims** for purposes of determining the **claim administrator's** fee payment to Prime. Each retail (including **claims** dispensed through PBM's Specialty Pharmacy program) paid **claim** will be weighted according to the days' supply dispensed. A paid **claim** is weighted in 34-day supply increments, so a 1-34 days' supply is considered 1 weighted **claim**, a 35-68 days' supply is considered 2 weighted **claims**, and the pattern continues up to 6 weighted **claims** for 171 or more days' supply. The **claim administrator** pays Prime a Program Management Fee (“PMF”) on a per weighted **claim** basis.

The amounts received by Prime from the **claim administrator**, **pharmacies**, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a **claim** is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the **claim administrator** (as described above), administrative fees charge by Prime to pharmacies and administrative fees charged by prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this benefit booklet.

Additional information about these types of fees or the amount of these fees is available upon request. As if the effective date, the maximum that PBM has disclosed to the **claim administrator** that the PBM will receive from any pharmaceutical manufacturer for manufacturer administrative fees is 5.5% of the Wholesale Acquisition Cost (“WAC") for all products of such manufacturer dispensed during any given calendar year to members of the **claim administrator**; and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation for which **claims** are submitted to the PBM at

the **claim administrator's** request, **provider**, however, that the **claim administrator** will advise the **employer** if such maximum has changed.

Claim Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers

The **claim administrator** owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the **claim administrator** has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers" or "PBMs") to provide, on the **claim administrator's** behalf, **claim payments** and certain administrative services for your **prescription** drug **benefits**. PBMs have agreements with pharmaceutical manufacturers to receive rebates for using their products. The PBM may share a portion of those rebates with the **claim administrator**. In addition, the mail-order **pharmacy** and specialty pharmacy operate through an affiliate partially owned by PRIME Therapeutics, LLC. Neither the **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.

Payment of Claims and Assignment of Benefits

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.

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.

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 any time before or after **covered services** are rendered to a covered person. Coverage under this health care plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a **claim** for **benefits** or coverage shall be null and void.

Balance Billing and Other Protections

Federal requirements, including but not limited to the Consolidated Appropriations Act, may impact your **benefits**. BCBS will apply federal requirements to your benefit plan, where applicable.

For some types of **out-of-network** care, your health care provider may not bill you more than your **in-network** cost-sharing levels. If you receive the types of care listed below, your cost-share will be calculated as if you received services from an **in-network provider**. Those cost-share amounts will apply to any **in-network deductible** and **out-of-pocket maximums**.

- Emergency care from facilities or **providers** who do not participate in your network.

- Care furnished by **non-participating providers** during your visit to an **in-network** facility.
- Air ambulance services from **non-participating providers** if your plan covers **in-network** air ambulance services.

There are limited instances when an **out-of-network provider** of the care listed above may send you a bill for up to the amount of that **provider's billed charge**s. You are only responsible for payment of the **out-of-network provider's billed charge**s if, in advance of receiving services, you signed a written notice that informed you of:

- The **provider's out-of-network** status.
- In the case of services received from an **out-of-network provider** at an **in-network** facility, a list of **in-network providers** at the facility who could offer the same services.
- Information about whether **prior authorization** or other care management limitations may be required in advance of services.
- A good faith estimate of the **provider's** charges.

Your **provider** cannot ask you to be responsible for paying **billed charge**s for certain types of services, including emergency medicine, anesthesiology, pathology, radiology, and neonatology, and other specialists as may be defined by applicable law.

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 interact with or provide any services to your **employer** (other than as an individual covered person) or your **employer's** ERISA health benefit program.

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.

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.

Information and Records

You agree that it is your responsibility to ensure that any **provider**, other BCBS plan, insurance company, **employee** benefit association, government body or program, any other person or entity, having knowledge of or records relating to:

a. Any illness or injury for which a **claim** or **claims** for **benefits** are made under the health care plan.
b. Any medical history which might be pertinent to such illness, injury, **claim** or **claims.**
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**, BCBS 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.

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 **deductible**s, 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**.

Identity Theft Protection Services

The **claim administrator** makes available, at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your

information. These identity theft protection services are currently provided by the **claim administrator**'**s** designated outside vendor and acceptance or declination of these services is optional to you. If you wish to accept such identity theft protection services you will need to individually enroll in the program online at www.bcbsil.com or telephonically by calling the toll-free telephone number on your **identification card**.

Services may automatically end if you no longer meet the definition of an **eligible person**. Services may change or be discontinued at any time with or without notice and the **claim administrator** does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered **benefits** under this benefit booklet.

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:

- The person to or for whom, such **benefits** were paid.
- Any insurance company or plan
- Any other persons, entities, or organizations, including, but not limited to **participating provider**s or **non**-**participating provider**s.

If no refund is received, your group's benefit plan and/or BCBS (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 health benefit plan, whether for the same or a different member.
- Made to any person or entity under another BCBS administered ASO benefit program.
- Made to any person or entity under another BCBS insured group benefit plan or individual policy.
- Or other payment, made to any person or entity.
- Owed to one or more participating or **non-participating providers.**

Further, the **claim administrator** has the right to reduce your **benefit** plan's payment to a provider by the amount necessary to recover another BCBS plan overpayment to the same provider and to remit the recovered amount to the other BCBS plan.

Claim Determinations and Interpretation of Employer's Plan Provisions

When **claim administrators** receives a properly submitted **claim**, it has authority and discretion under the benefit plan to interpret and determine **benefits** in accordance with the health benefit plan provisions. The group administrator has granted **claim administrator** discretionary authority to construe the terms and conditions of health benefit plan and the discretion to interpret and determine **benefits** in accordance with the health benefit plan's provisions.

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 **WHO GETS BENEFITS** of this benefit booklet).

The **benefits** and provisions described throughout this 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 benefit program is as follows:

1. Determine what the payment for a **covered service** would be following the payment provisions of this health benefit program.
2. Deduct from the charges eligible under **Medicare**, the amount paid 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**.)
3. The lesser of the two amounts determined in accordance with step 1 and step 2 above is the amount that will be paid under the health benefit program.

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.

Continuation Coverage Rights Under Cobra

This Continuation Coverage Rights Under COBRA section does not apply to your dependent who is a party to a civil union and their children.

Please Note: Certain **employers** may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your **employer** or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your **employer's** group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the plan and under federal law, you should review the Plan's Summary Plan Description or contact the **plan administrator**.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified

beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an **employee**, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an **employee**, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes enrolled in **Medicare benefits** (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happen:

- The parent-**employee** dies.
- The parent-**employee's** hours of employment are reduced.
- The parent-**employee's** employment ends for any reason other than his or her gross misconduct.
- The parent-**employee** becomes enrolled in **Medicare benefits** (under Part A, Part B, or both)
- The parents become divorced or legally separated.
- The child stops being eligible for coverage under the plan as a "**dependent** child."

If the plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your **employer**, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the **employer**, or the employee's becoming entitled to **Medicare benefits** (under Part A, Part B, or both), the **employer** must notify the plan administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the plan administrator within 60 days after the qualifying event occurs. Contact your **employer** and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to **Medicare benefits** (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to **Medicare benefits** less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of **Medicare** entitlement.

For example, if a covered employee becomes entitled to **Medicare** 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of **Medicare** entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your **employer** and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to **Medicare benefits** (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator.

Plan Contact Information

Contact your **employer** for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Continuation of Coverage for Parties to a Civil Union

The purpose of this section of your benefit booklet is to explain the options available for temporarily continuing your coverage after termination if you are covered under this health benefit program as the party to a **civil union** of an **eligible person** or as the dependent child of a party to a **civil union**. Your continued coverage under this health benefit program will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are a dependent who is party to a **civil union** or their child and you lose coverage under this health benefit program, you have the same options as the spouse or dependent child of an **eligible person** to continue your coverage. The options available to a spouse or a dependent child are described in the **Continuation Coverage Rights Under COBRA** section, if applicable to your Group.

NOTE: Certain **employers** may not be required to offer COBRA continuation coverage. See your group administrator if you have any questions about COBRA.

In addition to the events listed in the **Continuation Coverage Rights Under COBRA** section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your **civil union** partnership with the **eligible person** terminates. Your **civil union** partnership will terminate if your partnership no longer meets the criteria described in the definition of "**civil union**" in the **GLOSSARY** section of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

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 **allowable amount** 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**.")

Coordination of Benefits

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

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

- 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 **allowable amounts.**

- 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 BCBS, and upon its request to provide a copy, of such court decree.

- If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The **claim administrator** has the right in administering these COB provisions to:

- Pay any other organization an amount which it determines to be warranted if payments which should have been made by the **claim administrator** have been made by such other organization under any other group program.
- Recover any overpayment which the **claim administrator** may have made to you, any provider, insurance company, person or other organization.

In addition to the GLOSSARY section of this benefit booklet, the following definitions are applicable to this section:

Average Discount Percentage ("ADP") means a percentage discount determined by the **claim administrator** that will be applied to a **provider's allowable amount** for **covered services** rendered to you by **hospitals** and certain other health care facilities for purposes of calculating **coinsurance**, **deductible**s, **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 **allowable amounts** when your **benefits** under the health benefit program are secondary to **Medicare** and/or coverage under and other group program.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a **pharmacy**.

GLOSSARY

Allowable Amount means the maximum amount determined by us to be eligible for consideration of payment for a particular **covered service**, covered supply and **covered drug**. Your **deductible**, **coinsurance** and **copayment** are based on the **allowable amount** and the terms of your **plan**. Your share of **coinsurance** is a percentage of the **allowable amount** after the **deductible** is met.

Benefit Period means the period during which you receive **covered service**s for which the plan will provide **benefits**.

Benefits mean the payment, reimbursement and indemnification of any kind which you will receive from and through the plan under this contract.

Billed Charge means the total amount a provider charges for a service or item that is billed.

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

Brand Drug (Preferred) means a **brand drug**, that is identified on the **drug list** as a **brand drug (preferred)**. The **drug list** is accessible by accessing the **claim administrator**'s website at www.bcbsil.com.

Brand Drug (non-preferred) means a **brand drug** that is identified on the **drug list** as a **brand drug (non-preferred)**. The **drug list** is accessible by accessing the **claim administrator**'s website at www.bcbsil.com.

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

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

Claim Administrator means Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation. The **claim administrator** has no fiduciary responsibility for the operation of the Plan. The **claim administrator** assumed only the authority and discretion as given by the **employer** to interpret the plan provisions and make eligibility and benefit determinations.

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 **allowable amount** for **covered services** rendered to you, regardless of any separate financial arrangement between the **claim administrator** and a particular provider. (See provisions

regarding **The Claim Administrator's Separate Financial Arrangements with Providers** in the **GENERAL PROVISIONS** section of this benefit booklet.)

Coinsurance means the percentage of the allowed amount you pay as your share of the bill. For example, if your plan pays 80% of the **allowed amount**, 20% would be your **coinsurance**.

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

Copayment or Copay means the set amount you pay each time you receive a certain service.

Covered Drugs means any prescription drug:

- Which is included on the applicable **drug list.**
- Which is **medically necessary** and is ordered by an authorized **provider** for you or your **dependent.**
- Which is not consumed at the time and place that the **prescription order** is written.
- For which the FDA has given approval for at least one indication.
- Which is dispensed by a **pharmacy** and you received while covered under the plan, except when received from a **provider's** office, or during confinement while a patient in a **hospital** or other acute care institution or facility (refer to **Limitations and Exclusions**).

Note: **Covered drug(s)** under **PHARMACY BENEFITS** also means insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self-administration.

Course of Treatment means a prescribed order or ordered course if treatment for a specific individual with a specific condition, as outlined and decided upon ahead of time, with the patient and provider; may, but is not required to be part of a treatment plan.

Coverage Date means the date on which your coverage under the health benefit program begins.

Covered Service mean a service or supply shown in this certificate for which **benefits** will be provided.

Custodial Care Service means:

- Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition.
- 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.
- Services which can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (including but not limited to dressings, administration of routine medications, ventilator suctioning and other care etc.) and are to assist with activities of daily living (including but not limited to bathing, eating and dressing).

Deductible means the amount, if any, you must pay before we start paying contract **benefits**. You do not send this amount to us. We subtract this amount from covered expenses on **claims** you and health care professionals send us. Some services can be covered before the **deductible** is met. Refer to your **SUMMARY OF BENEFITS** for any **deductibles** applicable to your coverage.

Domestic Partner means a person with whom you have entered into a domestic partnership in accordance with the guidelines established by the plan in its affidavit or certification of domestic partnership. For purposes of this plan, domestic partners are not eligible beneficiaries for continuation under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For specific criteria or necessary forms required to establish eligibility for benefit coverage under this plan, contact your **employer** or Human Resources Department.

Note: Domestic partner coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **domestic partner** coverage is available under your **plan**.

Drug List means a list of drugs that may be covered under the **PHARMACY BENEFITS** section. A current list of available on the **claim administrator** 's website at bcbsil.com/member/prescription-drug-plan-information/drug-lists. You may also contact a Customer Service representative at telephone number shown on the back of your **identification card** for more information.

Eligible Person means an employee of the **employer** who meets the eligibility requirements for this health benefit program coverage, as described in the **WHO GETS BENEFITS** section of this benefit booklet.

Employer means the company with which you are employed.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical treatment of the condition being treated and any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Approval by a federal agency will be taken into consideration by BCBSIL in assessing **experimental/investigational** status but will not be determinative.

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

The medical staff of BCBSIL shall determine whether any treatment, procedure, facility, equipment, drug, device, new or existing technologies, or supplies are **experimental/investigational**, and will consider factors such as the guidelines and practices of Medicare, Medicaid, or other government-financed programs and approval by a federal agency in making its determination.

Although a **physician** or **other professional provider** may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, BCBSIL still may determine such services or supplies to be **experimental/investigational** within this definition. Treatment provided as part of a clinical trial or a research study is **experimental/investigational**. Prescription drugs that are approved by the FDA through the accelerated approval program may be considered **experimental/investigational.**

Family Coverage means coverage for you and your eligible dependents under the health benefit program.

Generic Drug means a drug that has the same active ingredient as a **brand drug** and is allowed to be produced after the **brand drug's** patent has expired. In determining the brand or generic classification for

covered drugs, the **claim administrator** utilizes the generic/brand status assigned by a nationally recognized **provider** of drug product database information. You should know that not all drugs identified as "generic" by the drug product database, manufacturer, **pharmacy** or your **physician** will adjudicate as generic. **Generic drugs** are listed on the **drug list** which is available by accessing the **claim administrator's** website at www.bcbsil.com. You may also contact Customer Service for more information.

Generic Drug (Non-Preferred) means a **generic drug** that is identified on the **drug list** as a generic drug (non-preferred). The **drug list** is accessible by accessing the **claim administrator's** website at www.bcbsil.com.

Generic Drug (Preferred) means a **generic drug,** that is identified on the **drug list** as a Preferred **brand drug (preferred)**. The **drug list** is accessible by accessing the **claim administrator**'s website at www.bcbsil.com.

Hospital means a short-term acute care facility which:

- Is duly licensed as a **hospital** by the state in which it is located and meets the standards established for such licensing, and is either accredited by The Joint Commission or is certified as a **hospital provider** under **Medicare**.
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of **physicians** or behavioral health **providers** for compensation from its patients.
- Has organized departments of medicine and major surgery, either on its premises or in facilities available to the **hospital** on a contractual prearranged basis and maintains clinical records on all patients.
- Provides 24-hour nursing services by or under the supervision of a Registered Nurse.
- Has a **hospital** utilization review plan in effect.

Identification Card means the card issued to the **employee** by BCBSIL indicating pertinent information applicable to their coverage.

Individual Coverage means coverage under the health benefit program for yourself but not your spouse and/or dependents.

In-Network Benefits means the **benefits** available under the **plan** for services and supplies that are provided by an **in-network provider** or an **out-of-network provider** when acknowledged by BCBSIL.

In-Network Provider means a **hospital**, **physician**, **behavioral health provider** or **other professional provider** who has entered into an agreement with BCBSIL (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care **provider**.

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

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

Medically Necessary or **Medical Necessity** means those services or supplies covered under the **plan** which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction.
- Provided following and are consistent with generally accepted standards of medical practice in the United States.
- Not primarily for the convenience of the participant, **physician**, behavioral health provider, the **hospital**, or the other provider.
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the participant. When applied to hospitalization, this further means that the participant requires acute care as a bed patient due to the nature of the services provided or the participant's condition, and the participant cannot receive safe or adequate care as an outpatient. BCBSIL does not determine course of treatment or whether particular health care services are received. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between the **participant**, **physician**, **behavioral health provider**, the **hospital**, or the **other provider.**

If more than one health intervention meets the requirements listed above, **medically necessary** means the most cost effective in terms of type, frequency, extent, site, duration, which is safe and effective for the patient's illness, injury, or disease.

The medical staff of BCBSIL shall determine whether a service or supply is **medically necessary** under the plan and will consider the views of the state and national medical communities, the guidelines and practices of **Medicare**, Medicaid, or other government-financed programs, and peer reviewed literature. Although a **physician**, **behavioral health provider** or other **provider** may have prescribed treatment, such treatment may not be **medically necessary** within this definition.

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 Eligible Expenses means expenses of the kinds covered by **Medicare** Parts A and B to the extent recognized as reasonable and **medically necessary** by **Medicare**.

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.

National Drug Code (NDC) means a national classification system for the identification of drugs.

Non-Participating Pharmacy or **Non-Participating Prescription Drug Provider** has the meaning set forth in the **GLOSSARY** section.

Out-of-Network means a **covered service** is rendered by an **administrator provider** which does not have a written agreement with the **claim administrator** to provide services to **participants** in a benefit program that utilizes the network. For purposes of the provision of this benefit booklet entitled, WARNING, LIMITED

BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED", a **non**-**participating provider** means a **professional provider** who renders **out-of-network covered services**.

Out-of-Pocket Maximum means once you pay this amount in **deductibles**, **copayments** and **coinsurance** for **covered services,** we pay 100% of the allowed amount for **covered services** for the rest of the **benefit period**.

Partial Hospitalization Treatment Program means our claim administrator approved the planned program of a hospital or substance use disorder treatment facility for the treatment of mental health conditions or substance use disorder treatment in which patients spend days or nights. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an inpatient unit, i.e., medically supervised by a physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Patients at this level of care do not require 24-hour supervision and are not considered a resident at the program. The **claim administrator** requires that any mental health condition and/or substance use disorder **partial hospitalization treatment program** 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.

Participating Pharmacy or **Participating Prescription Drug Provider** has the meaning set forth in the **GLOSSARY** section of this benefit booklet.

Pharmacy means a state and federally licensed establishment that is physically separate and apart from any **provider's** office, and where **legend drugs** and devices are dispensed under **prescription orders** to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state.

Pharmacy Vaccine Network means the **network** of select **participating pharmacies** which have a written agreement with us to provide certain vaccinations to you under this **plan**.

Physician means a person, when acting within the scope of their license, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine (MD) or Doctor of Osteopathy (DO) shall have the meaning assigned to them by the state of Illinois.

Post-Service Medical Necessity Review means the process of determining coverage after treatment has already occurred and is based on **medical necessity** guidelines. Can also be referred to as a retrospective review or post- service **claims** request.

Preferred Participating Pharmacy means a **participating pharmacy** which has a written agreement with Blue Cross and Blue Shield to provide pharmaceutical services to you or an entity chosen by the **claim administrator** to administer its prescription drug program that has been designated as a **Preferred participating pharmacy**.

Preferred Specialty Pharmacy Provider means a **participating prescription drug provider** that has a written agreement with the **claim administrator**, or an entity chosen by the **claim administrator** to administer its prescription drug program, to provide **specialty drugs** to you.

Prescription Order means a written or verbal order from a health care practitioner to a pharmacist for a drug to be dispensed. Prescriptions written by a health care practitioner located outside the United States to be dispensed in the United States are not covered under this Benefit Section.

Prior Authorization means the process that determines in advance the **medical necessity** or **experimental/investigational** nature of certain care and services under this **plan**.

Provider means a **hospital**, **physician**, **behavioral health provider**, **other provider**, or any other person, company, or institution furnishing to a **participant** an item of service or supply.

Recommended Clinical Review means an optional voluntary review of a **provider's** recommended medical procedure, treatment or test, that does not require **prior authorization**, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and **medical necessity** requirements.

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 level of security, supervision, and structure Medically Necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

Specialty Drugs means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of **specialty drugs** is subject to change. To determine which drugs are **specialty Drugs**, refer to the **drug list** by accessing the **claim administrator**'s website at www.bcbsil.com or call the customer service toll-free number on your **identification card**.

Specialty Drug (non-preferred) means a **specialty drug**, which may be a **generic** or **brand drug** that is identified on the **drug list** as a **specialty drug (non-preferred)**. The **drug list** is accessible by accessing the **claim administrator**'s website at www.bcbsil.com.

Specialty Drug (preferred) means a **specialty drug**, which may be a **generic** or **brand drug** that is identified on the **drug list** as a Preferred **specialty drug**. The **drug list** is accessible by accessing the **claim administrator**'s website at www.bcbsil.com.

Specialty Pharmacy Provider means a **participating prescription drug provider** that has a written agreement with the **claim administrator**, or the entity chosen by the **claim administrator** to administer its prescription drug program to provide **specialty drugs** to you.

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.
- Alleviating the condition being treated.
- Are appropriate for the **hospital** or other Facility Provider in which they were performed.
- 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 p**hysician** 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.

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.

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