AcademicBlue℠

Rosalind Franklin University Student Health Insurance Plan 2023-2024

Underwritten by:
Blue Cross and Blue Shield of Illinois

Please review to fully understand your coverage.

Medical Account Number: 125284

Schedule of Benefits

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

For questions concerning Out-of-Network Providers, please call Blue Cross and Blue Shield of Illinois customer service at 1-855-267-0214.

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

Unless otherwise specified, any Deductibles, Out-of-Pocket Maximums, Copayments, Coinsurance, and Benefit Maximums apply on a per Covered Person, per Benefit Period basis.

After the Deductible and any Copayments have been satisfied, benefits will be paid at the applicable benefit rate up to any maximum that may apply.

Deductible:	**In-Network Provider**	**Out-of-Network Provider**
Per Covered Person per Benefit Period:	$1,500	$4,500
Per Family per Benefit Period	$4,500	$13,500

If a Student has Family Coverage, each member of his/her family must satisfy the Deductible. If a Student's family has satisfied the family Deductible amount of $4,500 for Covered Expenses rendered by In-Network Provider(s) and a separate $13,500 family Deductible for Covered Expenses rendered by Out-of-Network Provider(s) or Non-Plan Provider(s), it will not be necessary for anyone else in a Student's family to meet the Deductible in that Benefit Period. That is, for the remainder of that Benefit Period only, no other family members(s) will be required to meet the Deductible before receiving benefits.

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

Once the Out-of-Pocket Maximum has been satisfied, with the exception of any applicable Out-of-Network Copayments, Covered Expenses will be payable at 100% for the remainder of the Benefit Period up to any maximum that may apply. Any Out-of-Network Copayments will continue to apply even after the Out-of-Pocket Maximum has been reached.

Out-of-Pocket Maximum:	**In-Network Provider**	**Out-of-Network Provider**
Per Covered Person per Benefit Period:	$5,400	$11,300
Per Family per Benefit Period	$10,800	$22,600

The In-Network Out-of-Pocket Maximum may be reached by:

- The In-Network Deductible;
- Charges for Outpatient Prescription Drugs;
- The Hospital emergency room Copayment;
- The Copayment for Doctor office visits;
- The Copayment for specialist office visits; and
- The payments for which a Covered Person is responsible after benefits have been provided (except for the cost difference between the Hospital's rate for a private room and a semi-private room or any expenses incurred for Covered Services rendered by an Out-of-Network Provider other than Emergency Care, and Inpatient treatment during the period of time when a Covered Person's condition is serious).

The following expenses cannot be applied to the In-Network Out-of-Pocket Maximum and will not be paid at 100% of the Allowable Amount when a Covered Person's In-Network Out-of-Pocket Maximum is reached:

- Charges that exceed the Allowable Amount;
- The Coinsurance resulting from Covered Services rendered by an Out-of-Network Provider;
- Penalty amounts for failing to follow Preauthorization requirements;
- Services, supplies, or charges limited or excluded in this Policy;
- Expenses not covered because a benefit maximum has been reached;
- Any Covered Expense paid by the primary Plan when BCBSIL is the secondary plan for purposes of coordination of benefits;
- Benefit reductions resulting from receiving Specialty Drugs from a Pharmacy which is not a Specialty Pharmacy Provider; or
- Benefit reductions resulting from receiving Prescription Drugs from a Non-Participating Pharmacy.

The Out-of-Network Out-of-Pocket Maximum may be reached by:

- The Out-of-Network Deductible;
- Charges for Outpatient Prescription Drugs;
- the Hospital emergency room Copayment; and
- the payments for Covered Services rendered by an Out-of-Network Provider for which a Covered Person is responsible after Benefits have been provided (except for the cost difference between the Hospital's rate for a private room and a semi-private room).

The following expenses cannot be applied to the Out-of-Network Out-of-Pocket Maximum and will not be paid at 100% of the Allowable Amount when a Covered Person's Out-of-Network Out-of-Pocket Maximum is reached:

- charges that exceed the Allowable Amount;
- the Coinsurance resulting from Covered Services a Covered Person may receive from an In-Network Provider;
- the Coinsurance resulting from Covered Services a Covered Person may receive from an Out-of-Network Hospital;
- penalty amounts for failing to follow Preauthorization requirements;
- services, supplies, or charges limited or excluded in this Policy;
- expenses not covered because a Benefit maximum has been reached; or
- any Covered Expenses paid by the Primary Plan when BCBSIL is the secondary plan for purposes of coordination of benefits.

If a Student has Family Coverage, each member of his/her family must satisfy the Out-of-Pocket Maximum. If a Student's family has satisfied the family Out-of-Pocket Maximum of $10,800 for Covered Expenses renderedby In-Network Provider(s) and a separate $22,600 family Out-of-Pocket Maximum for Covered Expenses rendered by Out-of-Network Provider(s), it will not be necessary for anyone else in a Student's family to meet the Out-of-Pocket Maximum in that Benefit Period. That is, for the remainder of that Benefit Period only, no other family member(s) will be required to meet the Out-of-Pocket Maximum before Covered Expenses (except for those expenses specifically excluded above and any Out-of-Network Copayments) will be payable at 100%.

Should the federal government adjust the Deductible and/or Out-of-Pocket Maximum applicable to this type of coverage, the Deductible and/or Out-of-Pocket Maximum in this Policy will be adjusted accordingly.

TO IDENTIFY IN-NETWORK AND OUT-OF-NETWORK HOSPITALS OR FACILITIES, COVERED PERSONS SHOULD CONTACT BLUE CROSS AND BLUE SHIELD CUSTOMER SERVICE AT 1-855-267-0214.

Covered Expenses:	In-Network Provider Covered Person Pays	Out-of-Network Provider* Covered Person Pays
Inpatient Expenses		
Hospital Expenses	20% of Allowable Amount $100 Copayment per Admission	40% of Allowable Amount
Surgical Expenses for a Primary Procedure	20% of Allowable Amount	40% of Allowable Amount
- Remaining Eligible Procedure	20% of Allowable Amount	40% of Allowable Amount
- Assistant Surgeon Services	20% of Allowable Amount	40% of Allowable Amount
- Anesthetist Services	20% of Allowable Amount	40% of Allowable Amount
Doctor's Visits	20% of Allowable Amount	40% of Allowable Amount
Mental Health/Chemical Dependency	20% of Allowable Amount	40% of Allowable Amount
Outpatient Expenses		
Surgical Expenses for a Primary Procedure	20% of Allowable Amount	40% of Allowable Amount
Remaining Eligible Procedures	20% of Allowable Amount	40% of Allowable Amount
Day Surgery/Outpatient Surgical Expenses	20% of Allowable Amount	40% of Allowable Amount
Day Surgery Miscellaneous Expenses	20% of Allowable Amount	40% of Allowable Amount
- Assistant Surgeon Services	20% of Allowable Amount	40% of Allowable Amount
- Anesthetist Services	20% of Allowable Amount	40% of Allowable Amount
Mental Health Care and Chemical Dependency	20% of Allowable Amount	40% of Allowable Amount
Emergency Room Accidents and Emergency Care (including Accidents, and Emergency and Non-Emergency Care for Behavioral Health Services)		
Facility Charges (excluding Certain Diagnostic Procedures)	20% of Allowable Amount $200 Copayment per visit (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment) Deductible Waived	
Physician Charges	20% of Allowable Amount	20% of Allowable Amount
Diagnostic X-ray and Laboratory Services	20% of Allowable Amount	40% of Allowable Amount

Covered Expenses:	In-Network Provider Covered Person Pays	Out-of-Network Provider* Covered Person Pays
Non-Emergency Care		
- Physician Charges	20% of Allowable Amount	40% of Allowable Amount
- Lab and X-ray Charges	20% of Allowable Amount	40% of Allowable Amount
Urgent Care	20% of Allowable Amount	40% of Allowable Amount
Radiation and Chemotherapy Services	20% of Allowable Amount	40% of Allowable Amount
Allergy Injection and Allergy Testing (Copayment may apply if billed in the office)	20% of Allowable Amount	40% of Allowable Amount
Chiropractic and Osteopathic Manipulation Benefits will be limited to 25 visits per Benefit Period	20% of Allowable Amount	40% of Allowable Amount
Preventive Care Services	No Charge	40% of Allowable Amount
Office Visits Including Office Visits for Behavioral Health Services Specialist Office Visit	$30 Copayment Deductible Waived $60 Copayment Deductible Waived	40% of Allowable Amount
Other Expenses		
Additional Surgical Opinion	20% of Allowable Amount	40% of Allowable Amount
Autism Spectrum Disorder	20% of Allowable Amount	40% of Allowable Amount
Durable Medical Equipment	20% of Allowable Amount	40% of Allowable Amount
Orthotic Devices	20% of Allowable Amount	40% of Allowable Amount
Habilitative Services and Devices	20% of Allowable Amount	40% of Allowable Amount
Ground and Air Ambulance Transportation**	20% of Allowable Amount	
Routine Well-Baby Care	No Charge	40% of Allowable Amount
Dental Treatment (Injury only to sound, natural teeth)	20% of Allowable Amount	40% of Allowable Amount
Tests and Procedures	20% of Allowable Amount	40% of Allowable Amount

Covered Expenses:	In-Network Provider Covered Person Pays	Out-of-Network Provider* Covered Person Pays
Mental Health Care and Chemical Dependency	20% of Allowable Amount	40% of Allowable Amount
Blood and Blood Components	20% of Allowable Amount	40% of Allowable Amount
Naprapathic Services Benefits will be limited to 15 visits per Benefit Period	20% of Allowable Amount	40% of Allowable Amount
Bariatric Surgery	20% of Allowable Amount	40% of Allowable Amount
Routine Pediatric Hearing Examinations	No Charge	40% of Allowable Amount
Organ and Tissue Transplants	20% of Allowable Amount	40% of Allowable Amount
Injections, when administered in the Doctor's office and charged on the Doctor's statement Deductible Waived	20% of Allowable Amount	40% of Allowable Amount
Abortion Services	20% of Allowable Amount	40% of Allowable Amount
Extended Care Expenses		
Skilled Nursing Facility No Benefit Period Visit Maximum	20% of Allowable Amount After a $100 Copayment	40% of Allowable Amount
Coordinated Home Health Care No Benefit Period Visit Maximum	20% of Allowable Amount	40% of Allowable Amount
Hospice Services No Benefit Period Visit Maximum	20% of Allowable Amount After a $100 Copayment	40% of Allowable Amount
Cardiac Rehabilitation Services Benefits will be limited to 36 visits per Benefit Period	20% of Allowable Amount	40% of Allowable Amount
Private Duty Nursing Services No Benefit Period Visit Maximum	20% of Allowable Amount	40% of Allowable Amount
Pulmonary Rehabilitation Therapy	20% of Allowable Amount	40% of Allowable Amount

The Copayment and Coinsurance amounts mentioned above are subject to change or increase as permitted by applicable law.

* Covered Persons will be responsible for the difference between the Allowable Amount and the billed charges, when receiving Covered Services from an Out-of-Network Provider. Out-of-Network Provider benefits will be paid by the Insurer at 60% of the Allowable Amount. Covered Persons will pay 40% of the Allowable Amount plus the difference between the Allowable Amount and the billed charges when receiving Covered Services from an Out-of-Network Provider. The Average Discount Percentage (as defined below in the Definitions" section) does not apply to Out-of-Network Providers.

** Notwithstanding anything else described herein, Providers of Ambulance Transportation will be paid based on the amount that represents the billed charges from the majority of the ambulance providers in the Chicago metro area, as submitted to Blue Cross and Blue Shield of Illinois.

Schedule of Benefits for Outpatient Prescription Drugs

Retail Pharmacy Deductible Per Covered Person per Benefit Period	**$150**

Copayments for Outpatient Prescription Drugs*:	**Preferred Participating and Participating Pharmacies**
Preferred Generic Drugs and diabetic supplies, insulin, and insulin syringes	$15 Copayment per prescription
Non-Preferred Generic Drugs and diabetic supplies, insulin, and insulin syringes	$15 Copayment per prescription
Preferred Brand Name Drugs and diabetic supplies, insulin, and insulin syringes	$40 Copayment per prescription
Non-Preferred Brand Name Drugs and diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	$100 Copayment per prescription, plus the cost difference between the Generic and Brand Name Drug or supplies per prescription
Preferred Specialty Drugs	$125 Copayment per prescription
Non-Preferred Specialty Drugs	$125 Copayment per prescription

***One prescription means up to a 30 consecutive day supply of a drug (except for certain drugs).**

Covered Persons can purchase a 90-day supply for 3 times the amount indicated above.

Covered Persons will be responsible for the difference between the amount paid by us under this Policy and the billed charges when receiving Prescription Drugs from a Non-Participating Pharmacy.

Non-Participating Pharmacies: When a Covered Person obtains Prescription Drugs, including diabetic supplies from a Non-Participating Pharmacy (other than a Participating Pharmacy), Benefits will be provided at 50% of the amount a Covered Person would have received had he/she obtained drugs from a Participating Pharmacy minus the Copayment amount or Coinsurance amount and will not apply to a Covered Person's Deductible.

Schedule of Pediatric Vision Coverage
For Covered Persons Under Age 19

Vision Care Services	**In-Network Cost or Discount** When a Copayment is due from the Covered Person, the remainder due is paidby this Policy, up to the covered charge *	**Out-of-Network Reimbursement** This is the maximum amount payable under this Policy, not to exceed the retailcost.
Exam (with dilation as necessary)	No Copayment	Up to $30
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are theresponsibility of the patient.		
Frames		
Provider Designated frames	No Copayment	Up to $75
Non-Provider Designated frames	$150 allowance on Non-Provider designated frame, 20% off balanceover $150	Not Covered
Lenses Standard Plastic, Glass, or Poly Spectacle Lenses		
Single Vision	No Copayment	Up to $25
Bifocal	No Copayment	Up to $40
Trifocal	No Copayment	Up to $55
Lenticular	No Copayment	Up to $55
Standard Progressive Lens	No Copayment	Up to $55
Premium Progressive Lens – Tier 1	$20 Copayment	Not Covered
Premium Progressive Lens – Tier 2	$30 Copayment	Not Covered
Premium Progressive Lens – Tier 3	$45 Copayment	Not Covered
Premium Progressive Lens – Tier 4	No Copayment $120 allowance, 20% off balance over $120	Not Covered
Lens Options – in addition to lens prices above		
UV Treatment	No Copayment	Up to $12
Tint (Fashion, Gradient, and Glass-Grey)	No Copayment	Up to $12
Standard Plastic Scratch Coating	No Copayment	Up to $12
Standard Polycarbonate	No Copayment	Up to $32

Standard Anti-Reflective Coating	$45 Copayment	Not Covered
Premium Anti-Reflective Coating Tier 1	$57 Copayment	Not Covered
Premium Anti-Reflective Coating Tier 2	$68 Copayment	Not Covered
Premium Anti-Reflective Coating Tier 3	20% off Retail Price	Not Covered
Polarized	20% off Retail Price	Not Covered
Glass	No Copayment	Up to $12
Photochromic/Transition Plastic	No Copayment	Up to $57
Oversized	No Copayment	Not Covered
Other Add-ons	20% off Retail Price	Not Covered
Contact Lenses – materials only		
Provider Designated Contact Lenses – No Copayment, covered 100% per supply listed below		
Extended Wear Disposables	Up to 6-month supply of monthly, or2-week disposable, single vision spherical or toric Contact Lenses	Up to $150
Daily Wear Disposables	Up to 3-month supply of daily disposable, single vision spherical Contact Lenses	Up to $150
Conventional	1 pair from selection of Provider Designated Contact Lenses	Up to $150
Medically Necessary Contact Lenses	No Copayment	Up to $210
Note: *In some instances, participating Providers may charge separately for the evaluation, fitting, or follow-up care relating to Contact Lenses. Should this occur, and the value of the contact lenses received is less than the allowance, a Covered Person may submit a Claim for the remaining balance (the combined reimbursement will not exceed the total allowance.*		
Value-added features: Laser vision correction: 15% off Retail Price, or 5% off promotional price. Mail-order contact lens replacement: www.contactsdirect.com. ***Value-Added Features*** *– In-Network Providers may offer discounted prices for non-covered lenses. Discounted prices may vary by state and are subject to change or discontinuance at any time without notice. THE DISCOUNTS ARE NOT INSURANCE.*		
Additional Benefits:		

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

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

Medically Necessary Contact Lenses are covered in lieu of other eyewear.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and Optometrists specializing in low vision care evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for Our Covered Person with low vision.

Covered Persons who require low-vision services and optical devices are entitled to the following coverage, both In and Out-of-Network:

Low Vision Evaluation: One comprehensive evaluation every five years. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems, perceiving contrast and lightning requirements for optimum vision.

Low-Vision Aid: Covered for one device per year such as high-power spectacles, magnifiers, and telescopes. These devices are utilized to maximize use of available vision, reduce problems of glare, or increase contract perception, based on the individual's visual goals and lifestyle needs.

Follow-up care: Four visits in any five-year period.

Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Covered Persons should ask their Provider for details of the warranty that is available to them.

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

300 E. Randolph Street Chicago, IL 60601

POLICYHOLDER:	Rosalind Franklin University
POLICY NUMBER:	125284 ("the Policy")
EFFECTIVE DATE:	July 1, 2023
POLICY TERM:	July 1, 2023 through June 30, 2024
PREMIUM DUE DATE:	On or before July 1, 2023 ("Policy Effective Date")

This Policy describes the terms and conditions of coverage as issued to the Policyholder named above. The Policy is issued in the state of Illinois and is governed by its laws. The Policy becomes effective at 12:01 A.M. on the Policy Effective Date at the Policyholder's address.

Blue Cross and Blue Shield of Illinois (herein referred to as "BCBSIL"), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (the "Insurer") and the Policyholder have agreed to all of the terms of the Policy as stated herein.

Policyholder has confirmed to Insurer that it is an Institution of higher education as defined in the Higher Education Act of 1965. This Policy does not make health insurance available other than in connection with enrollment as a Student (or a Dependent of a Student) in the Policyholder's Institution. If Covered Persons have any questions once they have read this Policy, they can call Us at 1-855-267-0214. It is important to all of Us that Covered Persons understand the protection this coverage gives them.

Signed for Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company by:

Stephen Harris
President, Illinois Division

Blue Cross and Blue Shield of Illinois
300 E. Randolph St.
Chicago, IL 60601

STUDENT HEALTH INSURANCE
PLEASE READ THIS POLICY CAREFULLY

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Notice

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

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a health Benefit plan's actuarial value, is not an indicator of the actual amount of expenses that a particular person will be responsible to pay out of his/her own pocket. A person's out of pocket expenses will vary depending on many factors, such as the particular health care services, health care Providers and particular Benefit plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular Benefit plan.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED

The Covered Person should be aware that when the Covered Persons elect to utilize the services of an Out-of-Network Provider for treatment, services and supplies not excluded or limited by the Policy, in non-emergency situations (except for Mental Illness or Substance Use Disorder services provided in a Hospital emergency department), Benefit payments to such Out-of-Network Providers are not based upon the amount billed. The basis of the Covered Person's Benefit payment will be determined according to the Covered Person's 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. THE COVERED PERSON CAN EXPECT TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Out-of-Network Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. In-Network Providers have agreed to accept discounted payments for services with no additional billing to the member other than applicable Copayments, Coinsurance and Deductible amounts. The Covered Person may obtain further information about the participating status of Providers and information on Out-of-Pocket Maximums by calling the toll-free telephone number on the back of their Identification Card. For questions concerning Out-of-Network Providers, please call Blue Cross and Blue Shield of Illinois customer service at 1-855-267-0214. Should the Covered Person wish to know the Allowable Amount for a particular health care service or procedure or whether a particular Provider is an In-Network Provider, an Out-of-Network Provider, or a Plan Provider, contact the Covered Person's Provider or Blue Cross and Blue Shield of Illinois. Should the Covered Person wish to know the estimated Claim Charge for a particular health care service or procedure, please contact the Covered Person's Provider.

Table of Contents

Important Information

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

UTILIZATION MANAGEMENT AND REVIEW

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on BCBSIL Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while some other services will be subject to a 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.

Refer to the definition of Medically Necessary under the DEFINITIONS sections of this Policy for additional information regarding any limitations and/or special conditions pertaining to your Benefits.

PRIOR AUTHORIZATION

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services for which you have obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

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 Policy. Blue Cross and Blue Shield recommends you confirm with your Provider if Prior Authorization has been obtained.

PRIOR AUTHORIZATION RESPONSIBILITY

Participating Provider Prior Authorization

Your Participating Provider is responsible for obtaining Prior Authorization, in those circumstances where authorization may be required. If Prior Authorization is not obtained and the services are denied as not Medically Necessary, the Participating Provider will be held responsible and will not be able to bill the Covered Person for the services.

For additional information about Prior Authorization for services outside of our service area, refer to the *Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements Notice* in the **NOTICES** section of this Policy.

Note: Providers that contract with other Blue Cross and Blue Shield Plans may not be familiar with the Prior Authorization requirements of BCBSIL. Unless a Provider contracts directly with BCBSIL as a Participating Provider, the Provider is not responsible for being aware of this Plan's Prior Authorization requirements, except as described in the *Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements Notice* in the **NOTICES** section of this Policy.

Non-Participating Provider Prior Authorization

If any Provider outside Illinois (except for those contracting as Participating Providers directly with BCBSIL) or any Non-Participating Provider recommends an Admission or a service that requires Prior Authorization, the Provider is not obligated to obtain the Prior Authorization for you. In such cases, it is your responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, you may be entirely responsible for the charges if determined not to be Medically Necessary. If the service is determined to be Medically Necessary, Out of-Network Benefits will apply. The Provider may call on your behalf, but it is your responsibility to ensure that BCBSIL is called.

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services for which you have obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

To determine if a specific service or category requires Prior Authorization, visit our website at www.bcbsil.com/find-

care/where-you-go-matters/utilization-management.com for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card to determine if Prior Authorization is required and/or to request a Prior Authorization.

Inpatient Admissions

Your Physician may need to obtain Prior Authorization from Blue Cross and Blue Shield for an Inpatient admission, if Inpatient admissions are identified as needing a Prior Authorization. In the case of an elective Inpatient admission, if services require an authorization, it is recommended that the call for Prior Authorization should be made as far in advance as possible but minimally within three calendar days before you are admitted unless it would delay Emergency Care. In an emergency, it is recommended that notification should take place as soon as possible but minimally within one calendar day after admission, or as soon thereafter as reasonably possible.

Your Participating Provider is required to obtain Prior Authorization for Inpatient admissions that may require Prior Authorization. If Prior Authorization is not obtained for Inpatient services and the services are denied as not Medically Necessary, the Participating Provider will be held responsible and will not be able to bill the Covered Person for the services.

If the Physician or Provider of services is not a Participating Provider then you, your Physician, Provider of services, or an authorized representative should obtain Prior Authorization by the Plan by calling one of the toll-free telephone numbers on the back of your Identification Card. The call should be made between 7:00 a.m. and 6:00 p.m., Central Time, on business days and 9:00 a.m. and 3:00 p.m., Central Time on Saturdays, Sundays and legal holidays. After working hours or on weekends, please call the toll-free telephone number on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

Participating Provider Benefits will be available if you use a Participating Plan Provider or Participating Specialty Care Provider. If you elect to use Non-Participating Providers for services and supplies available from Participating Providers, Non-Participating plan Benefits will be paid.

However, if care is not reasonably available from Participating Providers as defined by applicable law, and BCBSIL authorizes your visit to a Non-Participating Provider to be covered at the Participating Plan Benefit level prior to the visit, Participating Plan Benefits will be paid; otherwise, Non-Participating Plan Benefits will be paid.

When Prior Authorization of an Inpatient admission is obtained, a length-of-stay is assigned. Your Provider may seek an extension for the additional days if you require a longer stay. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the Length of Stay/Service Review subsection of this Policy.

For Behavioral Health Inpatient admissions please see **Contacting Behavioral Health** section below.

Prior Authorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

1. Maternity Care:

   a. 48 hours following an uncomplicated vaginal delivery;

   b. 96 hours following an uncomplicated delivery by caesarean section.

2. Treatment of Breast Cancer:

   a. 48 hours following a mastectomy;

   b. 24 hours following a lymph node dissection.

You or your Provider will not be required to obtain Prior Authorization from BCBSIL for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. 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 from BCBSIL.

OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW

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 Policy. BCBSIL recommends you confirm with your Provider if Prior Authorization has been obtained.

There may be general categories of Covered Services that require Prior Authorization.

To determine if a specific service or category requires Prior Authorization, visit our website at www.bcbsil.com/find-care/where-you-go-matters/utilization-management.com for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card.

For Behavioral Health Outpatient Service review please see the Contacting Behavioral Health section below.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this Policy.

Upon completion of the Inpatient or emergency admission review, Blue Cross and Blue Shield will send a letter to you, your Physician, Provider of services, Behavioral Health Practitioner and/or the Hospital or facility with a determination on the approved length of service or length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the *Appeal Procedure* section under this Policy.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to the Plan for continued services. If you, your Provider or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an Ongoing Course of Treatment, the Plan will make a determination on the request/appeal as soon as possible but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

RECOMMENDED CLINICAL REVIEW

Some services that do not require Prior Authorization may be subject to review for evidence of Medical Necessity for coverage determinations that may occur prior to services rendered, during the course of care or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations where you have to pay for a non-approved service. BCBSIL will review the request to determine if it meets approved BCBSIL medical policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbsil.com/find-care/where-you-go-matters/utilization-management.com for the Required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card. You or your Provider may request a Recommended Clinical Review.

Recommended Clinical Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions under this Policy. Please coordinate with your Provider to submit a written request for Recommended Clinical Review.

CONTACTING BEHAVIORAL HEALTH

You, your Physician or Provider of services or your authorized representative may contact BCBSIL for a Prior Authorization or Recommended Clinical Review by calling the toll-free telephone number on the back of your Identification Card and follow the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 6:00 PM, on weekends, and on holidays, the same behavioral health line is answered by clinicians available for Inpatient acute reviews only. Requests for residential or Partial Hospitalization are reviewed only during regular business hours.

General Provisions Applicable to All Recommended Clinical Reviews

1. No Guarantee of Payment

A Recommended Clinical Review is not a guarantee of Benefits or payment of Benefits by the Plan. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Policy. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the Covered Person may have become ineligible as of the date of service or the Covered Person's Benefits may have changed as of the date of service.

2. Request for Additional Information

The Recommended Clinical Review process may require additional documentation from the Covered Person's health care Provider or pharmacist. In addition to the written request for Recommended Clinical Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of this Policy.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or Post-Service Claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms member eligibility, availability of Benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered under certain circumstances.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment

A Post-Service Medical Necessity Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Policy. Post-Service Medical Necessity Review does not guarantee payment of Benefits by the Plan, for instance a Covered Person may become ineligible as of the date of service or the Covered Person's Benefits may have changed as of the date of service.

2. Request for Additional Information

The Post-Service Medical Necessity Review process may require additional documentation from the Covered Person's health care Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of this Policy.

CASE MANAGEMENT

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

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

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

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be based on generally accepted medical standards. Should the BCBSIL Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision, and your right to request an external review, will be provided to you, your Physician, and/or the Hospital or other Provider, within 24 hours, and will specify the dates that are not in Benefit. For further details regarding Medically Necessary care and other exclusions from coverage under this Policy, refer to the section entitled, "***Exclusions and Limitations***".

Note: If Benefits for Mental Illness or Substance Use Disorders are denied on the grounds that they are not Medically Necessary, you may request an expedited external review. However, your request must be initiated within 24 hours following written notification of the decision.

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

BCBSIL will make the initial decision whether hospitalization or other health care services or supplies were not Medically Necessary. In most instances, this decision is made by BCBSIL after you have been hospitalized or have received other health care services or supplies and after a Claim for payment has been submitted.

Remember that your BCBSIL Policy does not cover the cost of hospitalization, or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve an Inpatient admission or continued Inpatient hospitalization beyond the length of stay authorized by the BCBSIL Physician does not of itself make such an Inpatient Hospital stay Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views an Inpatient admission or continued Inpatient hospitalization beyond the length of stay assigned by BCBSIL as Medically Necessary, BCBSIL will not pay for an Inpatient admission or continued hospitalization which exceeds the assigned length of stay if BCBSIL and the BCBSIL Physician decide an extension of the assigned length of stay is not Medically Necessary.

However, if you or your Provider disagrees with the determination you have the right to appeal the decision. Please refer to the CLAIM APPEAL PROCEDURES provision in the ***Claim Provisions*** section for additional information.

APPEAL PROCEDURE

If you, your Physician, or Provider of health services disagree with the determination of BCBSIL prior to or while receiving services, that decision may be appealed by contacting BCBSIL.

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

Blue Cross and Blue Shield of Illinois
P.O. Box 3122
Naperville, Illinois 60566-9744

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

Additional information about appeals procedures is set forth in the CLAIM APPEAL PROCEDURES provision of the ***Claim Provisions*** section of this Policy.

FAILURE TO OBTAIN PRIOR AUTHORIZATION

If Prior Authorization is not obtained:

1. BCBSIL will review the Medical Necessity of your treatment or service prior to the final benefit determination.
2. If BCBSIL determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.

Definitions

Throughout this Policy, many words are used which have a specific meaning when applied to a Covered Person's health care coverage. These terms will always begin with a capital letter. When a Covered Person comes across these terms while reading this Policy, he/she can refer to these definitions because they will help them understand some of the limitations or special conditions that may apply to his/her Benefits. If a term within a definition begins with a capital letter, it means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER. In this Policy We refer to Our Company as "Blue Cross and Blue Shield of Illinois" or Insurer, and We refer to the Institution of higher education in which a Student is enrolled and active as the "Institution" or "Policyholder".

Not all defined words listed below may be applicable to this Policy, depending on the Benefits offered by your Institution. This includes the words Dependent and Domestic Partner, and any other word meant to apply solely to Dependents and/or Domestic Partners. This also applies to any definition that references Dependents and/or Domestic Partners. Please refer to your Outline of Coverage for eligibility information.

Accident means an Accident that results in accidental bodily damage, harm or Injury occurring while the Covered Person is insured under the Policy.

Allowable Amount means the maximum amount determined by Us to be eligible for consideration of payment for a particular service, supply, or procedure.

For Professional Providers - The Allowable Amount is the amount determined by Us which In-Network Providers have agreed to accept as payment in full for a particular Covered Expense. All Benefit payments for Covered Expenses rendered by Providers, whether In-Network or Out-of-Network, will be based on a schedule of Allowable Amounts.

For a Provider other than a Professional Provider which has a written agreement with Us or another Blue Cross and/or Blue Shield Plan to provide care to the Covered Person at the time Covered Expenses are incurred, the Allowable Amount is such Provider's Claim Charge for Covered Expenses.

For a Provider other than a Professional Provider which does not have a written agreement with Us or another Blue Cross and/or Blue Shield Plan to provide care to the Covered Person at the time Covered Expenses are incurred, the Allowable Amount will be the lesser of (unless otherwise required by Applicable Law or arrangement with the Out-of-Network Providers):

- the Provider's billed charges, or;
- Our non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare reimbursements and represents approximately 105% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Coordinated Home Health Care Program Covered Expenses will be 50% of the Out-of-Network Provider's standard billed charge for such Covered Expense (unless otherwise required by Applicable Law or arrangement with the Out-of-Network Providers).

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

When a Medicare reimbursement rate is not available for a Covered Expense or is unable to be determined on the information submitted on the Claim, the Allowable Amount for Out-of-Network Providers will be 50% of the Out-of-Network Provider's standard billed charge for such Covered Expense (unless otherwise required by Applicable Law or arrangement with the Out-of-Network Providers).

We will utilize the same Claim processing rules and/or edits that We utilize in processing In-Network Provider Claims for processing Claims submitted by Out-of-Network Providers which may also alter the Allowable Amount for a particular service. In the event We do not have any Claim edits or rules, We may utilize the

Medicare Claim rules or edits that are used by Medicare in processing the Claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share and graduate medical education payments.

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

For multiple Surgeries - The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

For Prescription Drugs as applied to a Preferred Participating Provider, Participating Provider and Non-Participating Provider Pharmacies - The Allowable Amount for pharmacies that are Preferred Participating or Participating Providers will be based on the provisions of the contract between Us and the Pharmacy in effect on the date of service. The Allowable Amount for pharmacies that are Non-Participating Providers will be based on the Average Wholesale Price.

Ambulance Transportation means local transportation in specially equipped certified ground and air transportation options from a Covered Person's 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 a Covered Person's home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this Policy.

Applicable Law or **Applicable** includes applicable laws and rules, including but not limited to statutes, ordinances, administrative decisions, and regulations.

Approved Clinical Trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is one of the following:

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

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

Average Discount Percentage (ADP) means a percentage discount determined by Us that will be applied to an Allowable Amount for Covered Expenses rendered to the Covered Person by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, Deductibles, Out-of-Pocket Maximums and/or Benefit maximums. The ADP Applicable to a particular Claim for Covered Expenses is the ADP, current on the date the Covered Expense is incurred, which is determined by Us to be relevant to the particular Claim. The ADP reflects Our 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 such costs. In determining the ADP applicable to a particular Claim, We will take into account differences among Hospitals and other facilities, the nature of the Covered Expenses involved and other relevant factors. The ADP shall not apply to Allowable Amounts when the Covered Person's Benefits under this Policy are secondary to Medicare and/or coverage under any other group program.

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

BCBSIL means Blue Cross and Blue Shield of Illinois, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (also referred to herein as "Insurer").

Behavioral Health Practitioner means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, or Substance Use Disorders.

Benefit means the payment, reimbursement, and indemnification of any kind which Covered Persons will receive from, and through, the Plan under this Policy.

Benefit Period means the period of time starting with the Effective Date of this Policy through the Termination Date as shown on the face page of this Policy. The Benefit Period is as agreed to by the Policyholder and the Insurer.

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.

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

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

Chiropractor means a duly licensed Chiropractor operating within the scope of such license.

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

Claim means notification in a form acceptable to Blue Cross and BlueShield 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 Blue Cross and Blue Shield of Illinois may requesting connection with services rendered to you.

Claim Charge means the amount which appears on a Claim as the Provider's charge for services rendered to the Covered Person, without adjustment or reduction and regardless of any separate financial arrangements between Us and a particular Provider.

Claim Payment means the Benefit payment calculated by Blue Cross and Blue Shield of Illinois, after submission of a Claim, in accordance with the Benefits described in this Policy. All Claim Payments will be calculated on the basis of the Allowable Amount for Covered Services rendered to a Covered Person, regardless of any separate financial arrangement between Blue Cross and Blue Shield of Illinois and a particular Provider.

Clinical Social Worker means a duly licensed Clinical Social Worker operating within the scope of such license.

Coinsurance means a percentage of an eligible expense that the Covered Person is required to pay towards a Covered Expense.

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

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

Contact Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to be fitted directly on your eye.

Controlled Substance means Schedule II, III, or IV Controlled Substances under the Illinois Controlled Substances Act.

Copayment means a fixed dollar amount that the Covered Person must pay before Benefits are payable under the Policy.

Covered Accident means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which Benefits are payable.

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Policy. Coverage under the Policy must remain continuously in force from the date the Accident or Sickness occurs until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service, or supply, that gave rise to the expense or the charge, was rendered or obtained.

Covered Person means any eligible Student or an eligible Dependent who applies for coverage, and for whom the required premium is paid.

Covered Service means a service or supply specified in this Policy 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 a Covered Person's condition. Custodial Care Services also means those services which do not require the technical skills, professional training, and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

Deductible means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a Policy Term basis before Benefits are payable under the Policy.

Dependent means:

- an Insured's lawful spouse including Domestic Partner; or
- an Insured's partner in a Civil Union (unless indicated otherwise, the term "spouse" includes a partner in a Civil Union); or
- an Insured's child(ren); or
- "Child(ren)" used hereafter in this Policy, means a natural child(ren), a stepchild(ren), foster child(ren), adopted child(ren), a child(ren) of a Student's Domestic Partner, a child(ren) who is in a Student's custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, a child(ren) of a Student's child(ren), grandchild(ren), child(ren) for whom a Student is the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, Student status, employment status, marital status, eligibility for other coverage or any combination of those factors. In addition, enrolled unmarried children will be covered up to the age of 30 if they:
    1) Live within the service area of Blue Cross and Blue Shield of Illinois network for this Policy;
    2) Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
    3) Have received a release or discharge other than a dishonorable discharge.

Coverage will continue for a child who is 26 or more years old, chiefly supported by the Insured and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Us within 31 days after the date the child ceases to qualify as a child for the reasons listed above. During the next two years, We may require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

Diagnostic Mammogram means a mammogram obtained using Diagnostic Mammography.

Diagnostic Mammography means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

Diagnostic Service means tests rendered for the diagnosis of a Covered Person's symptoms and which are directed toward evaluation or progress of a condition, disease, or Injury. Such tests include, but are not limited to, x-ray,

pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

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

Doctor means a Doctor licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certificate. It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

Domestic Partner means a person with whom a Student has entered into a Domestic Partnership.

Domestic Partnership means long-term committed relationship of indefinite duration with a person which meets the following criteria:

- a Student and his/her Domestic Partner have lived together for at least 6 months;
- neither a Student nor his/her Domestic Partner is married to anyone else or has another Domestic Partner;
- a Student's Domestic Partner is at least 18 years of age and mentally competent to consent to contract;
- a Student's Domestic Partner resides with him/her and intends to do so indefinitely;
- a Student and his/her Domestic Partner have an exclusive mutual commitment similar to marriage; and
- a Student and his/her Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

Drug List means a list of drugs that may be covered and/or preferred under the ***Outpatient Prescription Drug Program*** section of this Policy. A current list is available on our website at www.bcbsil.com. You may also call the customer service toll-free telephone number on the back of your Identification Card for more information.

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

Eligible Charge means: (1) in the case of a Provider, other than a Professional Provider, which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to participants in the Benefit program, or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan, at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and; (2) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to participants in the Benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan, at the time Covered Services are rendered, the following amount (unless otherwise required by Applicable Law or arrangement with the Non-Participating Provider):

1) the lesser of (unless otherwise required by Applicable Law or arrangement with the Non-Participating Provider) (A) the Provider's Billed Charges, and (B) an amount determined by Blue Cross and Blue Shield of Illinois to be approximately 105% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or
2) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (1) above based upon the information submitted on the Claim, the lesser of (unless otherwise required by Applicable Law or arrangement with the Non-Participating Provider) (A) the Provider's Billed Charges and (B) an amount determined by Blue Cross and Blue Shield of Illinois to be 150% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or
3) if the base Medicare reimbursement amount and the Maximum Allowance cannot be determined under subsections (1) or (2) above, based upon the information submitted on the Claim, then the amount will be 50% of the Provider's Billed Charges, provided, however, that Blue Cross and Blue Shield of Illinois may

limit such amount to the lowest contracted rate that Blue Cross and Blue Shield of Illinois has with a Participating Provider for the same or similar service based upon the type of Provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to the member (unless otherwise required by Applicable Law or arrangement with the Non-Participating Providers).

In addition to the foregoing, the Eligible Charge will be subject in all respects to Blue Cross and Blue Shield of Illinois Claim Payment rules, edits, and methodologies regardless of the Provider's status as a Participating Provider or Non-Participating Provider.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity.

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 woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- inadequately controlled pain; or
- with respect to a pregnant woman who is having contractions:
  1) inadequate time to complete a safe transfer to another Hospital before delivery; or
  2) a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and, within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

Experimental/Investigational Services and Supplies means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment of the condition being treated or 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.

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

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

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

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

Family Coverage means coverage for a Student and his/her eligible spouse and/or Dependents under this Policy.

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

Drugs and corresponding payment level, Blue Cross and Blue Shield of Illinois utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information. Generic Drugs are listed on the Drug List which is available on the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com. A Covered Person may also contact customer service at the toll-free telephone number on the back of your Identification Card for more information.

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

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 ear molds. This also includes Cochlear Implants.

Hearing Care Professional means a person who is a licensed Hearing Aid dispenser, licensed audiologist, or licensed Physician operating within the scope of such license.

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 on Accreditation of Healthcare Organizations 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 Practitioners 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;
    1) Provides 24-hour nursing services by or under the supervision of a Registered Nurse; and
    2) Has in effect a Hospital Utilization Review Plan.

Hospital also means a licensed alcohol and drug use disorder rehabilitation facility or a mental Hospital. Alcohol and drug use disorder rehabilitation facilities and mental Hospitals are not required to provide organized facilities for major Surgery on the premises on a prearranged basis.

Hospital Confined means a stay as a registered bed-patient in a Hospital. If a Covered Person is admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed-patient during for the duration in the Hospital, the admission shall be considered a Hospital Confinement.

Iatrogenic Infertility means an impairment of fertility by Surgery, radiation, Chemotherapy, or other medical treatment affecting reproductive organs or processes.

Identification Card means the card issued to the covered member by Blue Cross and Blue Shield of Illinois providing pertinent information applicable to his/her coverage.

Immediate Family means a Covered Person's parent, spouse, child, brother, or sister.

In-Network Provider means a Provider which has a written agreement with Us (or another Blue Cross and/or Blue Shield Plan) to provide services to the Covered Person at the time services are rendered to the Covered Person and has been designated by Us as an In-Network Provider.

Injury means accidental bodily injuries sustained by a Covered Person which are the direct cause of loss, independent of disease cause of loss, independent of disease or bodily infirmity and occurring while the insurance is in force. All Injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

Inpatient means that a Covered Person is a registered bed patient and is treated as such in a health care facility.

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorders or specializes in the treatment of cooccurring Mental Illness and Substance Use Disorders. Blue Cross and Blue Shield of Illinois requires that any Mental Illness 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 Blue Cross Blue Shield as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Institution means an Institution of higher education as defined in the Higher Education Act of 1965.

Insured means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An Insured is not a Dependent covered under the Policy.

Interscholastic Activities means playing, participating and/or traveling to or from an interscholastic, intercollegiate, club sports, professional, semi-professional sport, contest or competition, including practice or conditioning for such activity.

Intoxication means that which is defined and determined by the laws of the jurisdiction where the loss or cause of the loss was incurred.

Life Threatening Disease or Condition means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

Long Term Care Services means those social services, personal care services and/or Custodial Care Services needed by a Covered Person when he/she have lost some capacity for self-care because of a chronic illness, Injury, or condition.

May Directly or Indirectly Cause means the likely possibility that treatment will cause a side effect of infertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

Medical Care means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or Injury.

Medically Necessary or Medical Necessity means that a specific service or supply provided to the Covered Person is reasonably required for the treatment or management of a medical symptom or condition and that the service provided is the most efficient and economical service which can safely be provided to the Covered Person. When applied to Hospital Inpatient services, Medically Necessary means that the Covered Person's medical symptoms or condition require that the treatment be provided to the Covered Person as an Inpatient and that treatment cannot be safely provided to the Covered Person an Outpatient. Further, Medically Necessary means that Inpatient Hospital care and treatment will not be covered when the Covered Person's medical symptoms and condition no longer necessitate the Covered Person's continued stay in a Hospital. The fact that a Doctor or other health care Provider may prescribe, order, recommend or approve a service or supply does not of itself make such a service Medically Necessary. No Benefits will be provided for services which are not Medically Necessary.

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

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 or any mental health condition that occurs during pregnancy or during the postpartum period, including but not limited to, postpartum depression.

Naprapath means a duly licensed Naprapath operating within the scope of such license.

Naprapathic Services means the performance of Naprapathic practice by a Naprapath which may legally be rendered by them.

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

Non-Participating Prescription Drug Provider or **Non-Participating Pharmacy** means a Pharmacy, including but not limited to, and independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy, or Specialty Pharmacy which has not entered into a written agreement with any entity chosen by Blue Cross and Blue Shield to administer its prescription drug program for such Pharmacy to provide pharmaceutical services at the time Covered Services are rendered to participants in the benefit program.

Non-Preferred Brand Name Drug means a Brand Name Drug which appears on the applicable Drug List and is subject to the Non-Preferred Brand Name Drug Copayment. The Drug List is available by accessing the website at www.bcbsil.com.

Non-Preferred Generic Drug means a Generic Drug that is identified on the Drug List as a Non-Preferred Generic Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com.

Non-Preferred Specialty Drug means a Specialty Drug, which may be a Generic or Brand Name Drug, that is identified on the Drug List as a Non-Preferred Specialty Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com.

Occupational Therapist means a duly licensed Occupational Therapist operating within the scope of such license.

Out-of-Network Provider means a Provider that does not have a written agreement with Us (or another Blue Cross and/ or Blue Shield Plan) to provide services as an In-Network Provider to the Covered Person at the time services are rendered. The term Out-of-Network Provider includes both Plan Providers and Non-Plan Providers but does not include In-Network Providers. For questions concerning Out-of-Network Providers, please call the customer service toll-free telephone number on the back of your Identification Card.

Out-of-Pocket Maximum means the maximum liability that may be incurred by a Covered Person in a Benefit Period before Benefits are payable at 100% of the Allowable Amount.

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

Partial Hospitalization Treatment Program means a Hospital's planned therapeutic treatment program, which has been approved by your Participating IPA or Participating Medical Group or Substance Use Disorder. 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) and may typically run from 1 to 8 weeks duration. 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 it otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Participants 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 Illness 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 your Participating IPA or Participating Medical Group as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Participating Prescription Drug Provider or **Participating Pharmacy** means a Pharmacy, including, but not limited to, an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or Specialty Pharmacy that has a written agreement with a Blue Cross and/or Blue Shield Plan, or with the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide Covered Services to participants in the benefit program at the time Covered Services are rendered.

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 in which he practices.

Physical Therapist means a duly licensed Physical Therapist operating within the scope of such license.

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

Physician means a Physician duly licensed to practice medicine in all of its branches.

Policy means this Policy issued by Blue Cross and Blue Shield of Illinois to the Institution, the Institution's Application for Student Health Insurance, the Covered Person's application(s) for coverage, as appropriate, along with any exhibits, appendices, addenda and/or other required information.

Preauthorization means a requirement that the Covered Person must obtain authorization from BCBSIL before the Covered Person receives certain types of Covered Services designated by Blue Cross and Blue Shield of Illinois.

Preferred Brand Name Drug means a Brand Name Drug that is identified on the Drug List as a Preferred Brand Name Drug. The Drug List is accessible by accessing the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com.

Preferred Generic Drug means a Generic Drug that is identified on the Drug List as a Preferred Generic Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com.

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

Preferred Specialty Drug means a Specialty Drug that is identified on the Drug List as a Preferred Specialty Drug. The Drug List is accessible by accessing the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com.

Prescription Drug means: (1) prescription legend drugs; (2) compound medications of which at least one ingredient is a prescription legend drug; (3) Prescription Drugs that have been approved by the FDA for one protocol will be covered when found to be effective and prescribed for another; and (4) any other drugs that under the applicable state or federal law may be dispensed only upon written prescription of a Doctor.

Prescription Drugs will also include FDA approved female contraceptive drugs and devices and Outpatient contraceptive services.

Prescription Order means a written or verbal order from a Professional Provider to a pharmacist for a drug to be dispensed. Orders written by a Professional Provider located outside the United States to be dispensed in the United States are not covered under this Policy.

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

Podiatrist means a duly licensed Podiatrist operating within the scope of such license.

Professional Provider see definition of **Provider**.

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

- **Plan Provider** means a Provider which has a written agreement with Us (or another Blue Cross and/or Blue Shield Plan) to provide services to the Covered Person at the time services are rendered to the Covered Person.

- **Non-Plan Provider** means a Provider which does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

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

Qualifying Intercollegiate Sport means a sport: (1) which is not an Interscholastic Activity (as defined in this Policy); (2) which is administered by such Institution's department of intercollegiate athletics; and (3) for which Benefits for Covered Accidents are provided for and payable under this Policy while Insureds are playing, participating, and/or traveling to or from an intercollegiate sport, contest, or competition, including practice or conditioning for such activity.

Rehabilitative Services means including, but not limited to, Speech Therapy, Physical Therapy and Occupational Therapy. Treatment as determined by your Physician, that must be either (a) limited to therapy which is expected to result in significant improvement in the condition for which it is rendered, except as specifically provided for under the Autism Spectrum Disorder(s) provision and the plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of the therapy and indicate the diagnosis and anticipated goals, or (b) prescribed as preventive or maintenance Physical Therapy for members affected by multiple sclerosis. Rehabilitative Services must be expected to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, Injury or disabling condition.

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

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

- Has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or
- Is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a Psychologist with at least two years of supervised experience in health services.

Renal Dialysis Treatment means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

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

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

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

Routine Patient Costs do not include:

- the investigation item, device, or service, itself; or

- items and services which are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sickness means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

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, a Covered Person should refer to the Drug List by calling the toll-free telephone number on the back of your Identification Card or visiting Our website at www.bcbsil.com.

Specialty Pharmacy Provider or Specialty Pharmacy means a Pharmacy that has a written agreement with Blue Cross and Blue Shield of Illinois to provide Specialty Drugs to you or an entity chosen by Blue Cross and Blue Shield of Illinois to administer its Outpatient Prescription Drug Program that has been designated as a Specialty Pharmacy Provider.

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

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

Student means an individual Student or continued person who meets the eligibility requirements for this health coverage, as described in the eligibility requirements of this Policy. See your ***Outline of Coverage*** for eligibility requirements.

Student Administrative Health Fee means a fee charged by the Institution on a periodic basis to Students of the Institution to offset the cost of providing health care through health clinics regardless of whether the Students utilize the health clinics or enroll in Student health insurance. Student Administrative Health Fees are not considered Deductibles, Coinsurance, Copayments, or other cost sharing for purposes of the Preventive Care Services Benefit, and do not count toward maximums.

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

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

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

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

Telehealth and Telemedicine Services means a health service delivered using telecommunications and information technology by a health care professional licensed, certified, or registered to practice in Illinois and acting within the

scope of his/her license, certification, or registration to a patient in a different physical location than the health care professional.

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.

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; or
- with the presence of signs or symptoms compatible with acute infection of borrelia or other Tick-Borne Diseases.

Virtual Provider means a licensed Provider who has a written agreement with Blue Cross and Blue Shield of Illinois to provide diagnosis and treatment of injuries and illnesses through either: (1) interactive audio communication (via telephone or other similar technology); or (2) interactive audio/video examination and communication (via online portal, mobile application, or similar technology) to you at the time services are rendered, operating within the scope of such license.

Virtual Visit means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the VIRTUAL VISITS provision under the ***Additional Benefits*** section of this Policy.

We, Our, Us means Blue Cross and Blue Shield of Illinois or its authorized agent.

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

For questions concerning Out-of-Network Providers, please call Blue Cross and Blue Shield of Illinois customer service at 1-855-267-0214.

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

Unless otherwise specified, any Deductibles, Out-of-Pocket Maximums, Copayments, Coinsurance, and Benefit Maximums apply on a per Covered Person, per Benefit Period basis.

After the Deductible and any Copayments have been satisfied, benefits will be paid at the applicable benefit rate up to any maximum that may apply.

If a Student has Family Coverage, each member of his/her family must satisfy the Deductible. If a Student's family has satisfied the family Deductible amount shown on your Medical Benefit Highlights for Covered Expenses rendered by In-Network Provider(s) and a separate family Deductible amount shown on your Medical Benefit Highlights for Covered Expenses rendered by Out-of-Network Provider(s) or Non-Plan Provider(s), it will not be necessary for anyone else in a Student's family to meet the Deductible in that Benefit Period. That is, for the remainder of that Benefit Period only, no other family members(s) will be required to meet the Deductible before receiving benefits.

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

Once the Out-of-Pocket Maximum has been satisfied, with the exception of any applicable Out-of-Network Copayments, Covered Expenses will be payable at 100% for the remainder of the Benefit Period up to any maximum that may apply. Any Out-of-Network Copayments will continue to apply even after the Out-of-Pocket Maximum has been reached.

The In-Network Out-of-Pocket Maximum may be reached by:

- The In-Network Deductible;
- Charges for Outpatient Prescription Drugs;
- The Hospital emergency room Copayment;
- The Copayment for Doctor office visits;
- The Copayment for specialist office visits; and
- The payments for which a Covered Person is responsible after benefits have been provided (except for the cost difference between the Hospital's rate for a private room and a semi-private room or any expenses incurred for Covered Services rendered by an Out-of-Network Provider other than Emergency Care, and Inpatient treatment during the period of time when a Covered Person's condition is serious).

The following expenses cannot be applied to the In-Network Out-of-Pocket Maximum and will not be paid at 100% of the Allowable Amount when a Covered Person's In-Network Out-of-Pocket Maximum is reached:

- Charges that exceed the Allowable Amount;
- The Coinsurance resulting from Covered Services rendered by an Out-of-Network Provider;
- Penalty amounts for failing to follow Preauthorization requirements;
- Services, supplies, or charges limited or excluded in this Policy;
- Expenses not covered because a benefit maximum has been reached;
- Any Covered Expense paid by the primary Plan when BCBSIL is the secondary plan for purposes of coordination of benefits;
- Benefit reductions resulting from receiving Specialty Drugs from a Pharmacy which is not a Specialty Pharmacy Provider; or
- Benefit reductions resulting from receiving Prescription Drugs from a Non-Participating Pharmacy.

The Out-of-Network Out-of-Pocket Maximum may be reached by:

- The Out-of-Network Deductible;
- Charges for Outpatient Prescription Drugs;
- the Hospital emergency room Copayment; and
- the payments for Covered Services rendered by an Out-of-Network Provider for which a Covered Person is responsible after Benefits have been provided (except for the cost difference between the Hospital's rate for a private room and a semi-private room).

The following expenses cannot be applied to the Out-of-Network Out-of-Pocket Maximum and will not be paid at 100% of the Allowable Amount when a Covered Person's Out-of-Network Out-of-Pocket Maximum is reached:

- charges that exceed the Allowable Amount;
- the Coinsurance resulting from Covered Services a Covered Person may receive from an In-Network Provider;
- the Coinsurance resulting from Covered Services a Covered Person may receive from an Out-of-Network Hospital;
- penalty amounts for failing to follow Preauthorization requirements;
- services, supplies, or charges limited or excluded in this Policy;
- expenses not covered because a Benefit maximum has been reached; or
- any Covered Expenses paid by the Primary Plan when BCBSIL is the secondary plan for purposes of coordination of benefits.

If a Student has Family Coverage, each member of his/her family must satisfy the Out-of-Pocket Maximum. If a Student's family has satisfied the family Out-of-Pocket Maximum shown on your Medical Benefit Highlights for Covered Expenses rendered by In-Network Provider(s) and a separate amount shown on your Medical Benefit Highlights family Out-of-Pocket Maximum for Covered Expenses rendered by Out-of-Network Provider(s), it will not be necessary for anyone else in a Student's family to meet the Out-of- Pocket Maximum in that Benefit Period. That is, for the remainder of that Benefit Period only, no other family member(s) will be required to meet the Out-of-Pocket Maximum before Covered Expenses (except for those expenses specifically excluded above and any Out-of-Network Copayments) will be payable at 100%.

Should the federal government adjust the Deductible and/or Out-of-Pocket Maximum applicable to this type of coverage, the Deductible and/or Out-of-Pocket Maximum in this Policy will be adjusted accordingly.

TO IDENTIFY IN-NETWORK AND OUT-OF-NETWORK HOSPITALS OR FACILITIES, COVERED PERSONS SHOULD CONTACT BLUE CROSS AND BLUE SHIELD CUSTOMER SERVICE AT 1-855-267-0214.

We will pay the Covered Expenses as shown in the Medical Benefit Highlights if a Covered Person requires treatment by a Doctor. We will consider the Allowable Amount incurred for Medically Necessary Covered Expenses. Benefit payments are subject to the Deductibles, Copayments, Coinsurance amounts, and Benefit maximums, if any, shown in the Medical Benefit Highlights as well as any other terms, conditions, limitations, or exclusions described in this Policy.

Covered Expenses include:

Inpatient Expenses

Hospital Expenses:

- Daily room and board at a semi-private room rate when Hospital Confined;
- General nursing care provided and charged for by the Hospital;
- Intensive care. We will make this payment in lieu of the semi-private room expenses;
- Coordinated home care Benefits following Hospital Confinement;
- Hospital Miscellaneous Expenses: expenses incurred while Hospital Confined or as a precondition for being Hospital Confined, for services and supplies such as the cost of operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, Physical Therapy, therapeutic services, and supplies. In computing the number of days payable under this Benefit, the date of admission will be counted but not the date of discharge;

- Surgical Expense: Surgeon's fees for Inpatient Surgery paid as shown in the Medical Benefit Highlights. If an Injury or Sickness requires multiple surgical procedures, We will cover according to the Allowable Amount shown in the Medical Benefit Highlights;
- Preadmission Testing: when Medically Necessary, in connection with Inpatient Surgery;
- Assistant Surgeon Services: when Medically Necessary, in connection with Inpatient Surgery;
- Anesthetist Services: in connection with Inpatient Surgery;
- Doctor's Visits: when Hospital Confined. Benefits do not apply when related to Surgery and will be paid as a Covered Inpatient Expense as shown in the Medical Benefit Highlights;
- Staff nursing care while confined to a Hospital by a licensed registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN);
- Routine Costs for Participants in Approved Clinical Trials: Benefits will be provided for Routine Patient Costs in connection with a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law; and
- Rehabilitative Services.

When you receive Covered Services, in an in-network Hospital or in an in-network ambulatory surgical facility and, due to any reason, Covered Services provided by an anesthesiologist (including a Certified Registered Nurse Anesthetist), pathologist, radiologist, neonatologist, emergency room Physician, assistant surgeon (if the primary surgeon is an In-Network Provider) or other Physician who is not an In-Network Provider are unavailable from an In-Network Provider and Covered Services are provided by an Out-of-Network Provider, you will incur no greater out-of-pocket costs than you would have incurred if the Covered Services were provided by an In-Network Provider.

Outpatient Expenses

- Day Surgery/Outpatient Surgical Expenses: Surgeon's fees for Outpatient Surgery paid as shown in the Medical Benefit Highlights. If an Injury or Sickness requires multiple surgical procedures, We will cover according to the Allowable Amount shown in the Medical Benefit Highlights.
- Day Surgery Miscellaneous Expenses: Services related to scheduled Surgery performed in a Hospital or ambulatory surgical center, including operating room expenses, laboratory tests and diagnostic test expense, examinations, including professional fees, anesthesia, drugs or medicines, and therapeutic services and supplies.

Benefits will not be paid for Surgery performed in a Hospital emergency room, Doctor's office, or clinic.

Benefits for oral Surgery are limited to the following services:

- 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 correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; and
- 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.
- Preadmission Testing: when Medically Necessary, in connection with Outpatient Surgery;
- Assistant Surgeon Services: when Medically Necessary, in connection with Outpatient Surgery;
- Anesthetist Services: in connection with Outpatient Surgery;
- Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon's office, Hospital, or ambulatory surgical facility if you are under age 26 and have been diagnosed with an Autism Spectrum Disorder or a developmental disability;

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

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

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

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

(2) It manifested before the age of 22;

(3) It is likely to continue indefinitely; and

(4) It results in substantial functional limitations in 3 or more of the following areas of major life activity: (a) self-care; (b) language; (c) learning; (d) mobility; (e) self-direction; and (f) the capacity for independent living.

- Doctor's Visits: Benefits will be paid as shown in the Medical Benefit Highlights. Doctor visits related to Surgery or Physical, Occupational or Speech Therapy or Chiropractic and Osteopathic Manipulation or Diagnostic Services, CT scans, PET scans or MRIs and Benefits will be paid as a Covered Outpatient Expense as shown in the Medical Benefit Highlights;
- Physical, Occupational and Speech Therapy Expenses;
- Diagnostic X-ray and Laboratory Services: when Medically Necessary and performed by a Doctor will include Diagnostic Services and medical procedures performed by a Doctor, other than Doctor's visits, X-ray, and lab procedures;
- Medical Emergency Expenses: only in connection with Emergency Care as defined. Benefits will be paid as shown in the Medical Benefit Highlights for the use of the emergency room and supplies. However, Medical Emergency Covered Services received for the examination and testing a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Allowable Amount whether or not a Covered Person has met their Deductible. The emergency room Copayment will not apply;
- Urgent Care;
- Radiation & Chemotherapy;
- Electroconvulsive Therapy;
- Renal Dialysis Treatments: If received in a Hospital, a Dialysis Facility or in a Covered Person's home under the supervision of a Hospital or Dialysis Facility;
- Allergy Injections and Allergy Testing;
- Chiropractic and Osteopathic Manipulation: Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and Osteopathic manipulation, when performed by a person licensed to perform such procedures;
- Diabetes Self-Management Training and Education: Benefits will be provided for Outpatient self-management training, education, and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered, or licensed health care professional with expertise in diabetes management. Benefits for such health care professionals will be paid as an Other Covered Expense as shown in the Medical Benefit Highlights. Benefits for Physicians will be paid as a Covered Outpatient Expense as shown in the Medical Benefit Highlights. Benefits are also available for regular foot care examinations by a Physician or Podiatrist;
- Routine Patient Costs for Participants in Approved Clinical Trials: Benefits will be provided for Routine Patient Costs in connection with a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law;
- Rehabilitative Services;
- Immune Gamma Globulin Therapy (IGGT): Benefits will be provided for immune gamma globulin therapy for Covered Persons diagnosed with a primary immunodeficiency when prescribed as Medically Necessary by a Physician. Nothing shall prevent Blue Cross and Blue Shield of Illinois from applying appropriate utilization review standards to the ongoing coverage of IGGT;

- Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)/Pediatric Acute Onset Neuropsychiatric Syndrome (PANS) Treatment - Benefits will be provided for all Medically Necessary treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including coverage for Medically Necessary intravenous immunoglobulin therapy;
- For persons diagnosed with a primary immunodeficiency. Subject to such utilization review standards, an initial authorization shall be for no less than three months and reauthorization may occur every six months thereafter. For persons who have been in treatment for two years, reauthorization shall be no less than every 12 months, unless more frequently indicated by a Physician;
- Outpatient Contraceptive Services: Benefits will be provided for injections, implants, and Outpatient contraceptive services. Outpatient contraceptive services includes, but are not limited to, consultations, patient education, counseling on contraception, examinations, procedures, and medical services provided on an Outpatient basis and related to the use of contraceptive methods;
- Benefits will be provided for Medically Necessary contraceptive devices, injections and implants approved by the federal food and drug administration, as prescribed by your Physician, follow-up services related to drugs, devices, products, procedures, including but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal;
- Benefits for Outpatient contraceptive services will not be subject to any Deductible, Coinsurance and/or Copayment when such services are received from an In-Network Provider.

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 Policy, the terms of this section will apply. However, definitions set forth in the ***Federal No Surprises Act Definitions*** provision of this section are for purposes of this section only.

- **Continuity of Care**

If you are under the care of a Participating Provider as defined in this Policy who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

- You are undergoing a course of treatment for a serious and complex condition;
- You are undergoing institutional or inpatient care;
- You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery);
- You are pregnant or undergoing a course of treatment for your pregnancy; or
- You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition); and (2) for a chronic illness or condition, is (a) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (b) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies you of the Provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the ***Claim Appeal Procedures*** provision in the ***Claim Provisions*** section of this Policy.

- **Federal No Surprises Act Definitions**

The definitions below apply only to this ***FEDERAL BALANCE BILLING AND OTHER PROTECTIONS*** section. To the extent the same terms are also defined in the ***Definitions*** section of this Policy, those terms will apply only to their use in the Policy or this ***FEDERAL BALANCE BILLING AND OTHER PROTECTIONS*** section, respectively.

Air Ambulance Services means, for purposes of this section only, medical transport by helicopter or airplane for patients.

Emergency Medical Condition means, for purposes of this section only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (1) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (2) constituting a serious impairment to bodily functions; or (3) constituting a serious dysfunction of any bodily organ or part.

Emergency Services means, for purposes of this section only, a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department and further medical examination or treatment you receive at a Hospital, regardless of the department of the Hospital or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until your condition is stabilized; and (2) Covered Services you receive from a Non-Participating Provider during the same visit after your Emergency Medical Condition has stabilized unless: (a) Your Non-Participating Provider determines you can travel by non-medical or non-emergency transport; (b) Your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and (c) You have provided informed consent.

Non-Participating Provider means, for purposes of this section only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan.

Non-Participating Emergency Facility means, for purposes of this section only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan.

Participating Provider means, for purposes of this section only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan, regardless of whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the Plan.

Participating Facility means, for purposes of this section only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan, regardless of whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the Plan.

Qualifying Payment Amount means, for purposes of this section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

Recognized Amount means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

- **Federal No Surprises Act Surprise Billing Protections**

The Federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below:

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility;
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections); and
- Air Ambulance Services received from a Non-Participating Provider if the services would be covered if received from a Participating Provider.

- **Claim Payments**

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

- **Cost-Sharing**

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward your Participating Provider Deductible and/or Out-of-Pocket Limit, if any.

- **Federal No Surprises Act Prohibition of Balance Billing**

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill you is your in-network cost-share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

Additional Benefits

Please refer to your Medical Benefit Highlights for detailed information regarding these Benefits.

ADDITIONAL SURGICAL OPINION

A Covered Person's coverage includes Benefits for an additional surgical opinion following a recommendation for elective Surgery. A Covered Person's Benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge. A Covered Person's Deductible will not apply to this Benefit. If a Covered Person requests, Benefits will be provided for an additional consultation when the need for Surgery, in his/her opinion, is not resolved by the first arranged consultation.

CARDIAC REHABILITATION SERVICES

A Covered Person's Benefits for cardiac rehabilitation services are the same as his/her Benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield of Illinois approved programs. Benefits are available if a Covered Person has 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.

DURABLE MEDICAL EQUIPMENT

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

AMINO ACID-BASED ELEMENTAL FORMULAS

Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary.

ORTHOTIC DEVICES

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

AMBULANCE SERVICE

Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation. When receiving Benefits for Ambulance Transportation related to Emergency Care, Covered Persons will not be responsible for amounts other than those listed in the Medical Benefit Highlights.

NON-EMERGENCY FIXED-WING AMBULANCE TRANSPORTATION

Non-Emergency Fixed-Wing Ambulance Transportation. Please refer to the definition of "Non-Emergency Fixed-Wing Ambulance Transportation" in the ***Definitions*** section of this Policy for additional information regarding any limitations and/or special conditions pertaining to your Benefits.

EMERGENCY SERVICES

If the Covered Person must be hospitalized in an out-of-network Hospital immediately following Emergency Accident Care or Emergency Medical Care, Benefits will be provided at the In-Network Provider Hospital payment level for that portion of the Covered Person's Inpatient Hospital stay during which the Covered Person's condition is determined to be serious and therefore not permitting the Covered Person's safe transfer to an in-network Hospital or other In-Network Provider. For that portion of the Covered Person's Inpatient Hospital stay during which the Covered Person's condition is determined not to be serious, Benefits will be provided at 50% of the Allowable Amount for Covered Services if the Covered Person is in a Non-Plan Hospital in an emergency department, or at the Out-of-Network Provider Hospital payment level if the Covered Person is in an out-of-network Hospital in an emergency department. For the Covered Person to continue to receive Benefits at the in-network Hospital payment level following an emergency admission to an out-of-network Hospital, the Covered Person must transfer to an in-network Hospital or

other In-Network Provider as soon as the Covered Person's condition is no longer serious. To identify Plan Hospitals or facilities, the Covered Person should contact Blue Cross and Blue Shield of Illinois by calling the toll-free telephone number on the back of their Identification Card or visiting Our website at www.bcbsil.com.

Services provided in a Hospital emergency department that are not Emergency Medical Care or Emergency Accident Care may be excluded from emergency coverage, although these services may be covered under another Benefit, if applicable. Non-Emergency Services provided in a Hospital emergency department for treatment of Mental Illness or Substance Use Disorder will be paid the same as Emergency Medical Care and Emergency Accident Care services.

CONSULTANT DOCTOR FEES

When requested and approved by the attending Doctor.

FERTILITY PRESERVATION SERVICES

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

HUMAN BREAST MILK COVERAGE

Benefits for pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed medical practitioner, will be provided for a covered infant under the age of 6 months, if the following conditions have been met:

- the milk is prescribed by a licensed practitioner;
- 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 mother 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 for the infant; and
- one or more of the following applies:
  (1) the infant's birthweight is below 1,500 grams;
  (2) the infant has a congenital or acquired condition that places the infant at a high risk for developing necrotizing enterocolitis;
  (3) the infant has infant hypoglycemia;
  (4) the infant has congenital heart disease;
  (5) the infant has had, or will have, an organ transplant;
  (6) the infant has sepsis; or
  (7) the infant has any other serious congenital or acquired condition for which the use of donated breast milk is Medically Necessary and supports the treatment and recovery of the infant.

For more information about this Benefit, you can call the toll-free telephone number on the back of your Identification Card or visit Our website at www.bcbsil.com.

INFERTILITY EXPENSES

Benefits will be provided the same as a Covered Person's Benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility, or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy. The one year requirement will be waived if a Covered Person's Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy. Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device, or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

In-vitro Fertilization Expenses: Benefits will be paid for Outpatient expenses only when:

- A Covered Person has been unable to attain a viable pregnancy, maintain a viable pregnancy, or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if a Student or his/her partner has a medical condition that makes such treatment useless. Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per Benefit Period, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered per Benefit Period; and
- Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to a Covered Person. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings, and Prescription Drugs.

If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count as one completed oocyte retrieval. Following the fourth completed oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to a Covered Person.

SPECIAL LIMITATIONS FOR THE DIAGNOSIS AND TREATMENT OF INFERTILITY

Benefits will not be provided for the following:

- Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm or embryos from a Covered Person will be covered if he/she chooses to use a surrogate;
- Expenses incurred for cryo-preservation or storage of sperm, eggs, or embryos, except for those procedures which use a cryo-preserved substance. Please note, that Benefits may be provided for fertility preservation as set forth in the "FERTILITY PRESERVATION SERVICES" provision of this Policy;
- Non-medical costs of an egg or sperm donor;
- Travel costs for travel within 100 miles of a Covered Person's home or travel costs not Medically Necessary or required by BCBSIL;
- Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists; and
- Infertility treatment rendered to a Student's Dependents under age 18.

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

The Insurer will pay the actual expenses incurred, including Medically Necessary maternity testing, as a result of pregnancy, childbirth, miscarriage, or any Complications of Pregnancy resulting from any of these. Pregnancy Benefits will also cover a period of hospitalization for maternity and newborn infant care for:

- a minimum of 48 hours of Inpatient care following a vaginal delivery; or
- a minimum of 96 hours of Inpatient care following delivery by cesarean section.

Covered Persons' Providers will not be required to obtain authorization from Blue Cross and Blue Shield of Illinois for prescribing a length of stay less than 48 hours (or 96 hours).

If the Doctor, in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a Provider's office, as determined by the Doctor in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, Doctor, nurse practitioner, nurse midwife, or Physician's assistant experienced in maternal and child health, and shall include:

- Parental Education;
- Assistance and training in breast or bottle feeding;
- Performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening; and
- Routine Well-Baby Care: (1) while the baby is Hospital Confined; and (2) for routine nursery care provided within the first 31 days after birth, including treatment of diagnosed congenital and birth abnormalities.

DENTAL TREATMENT (INJURY ONLY)

When performed by a Doctor and made necessary by Injury to sound, natural teeth. If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted dental standards of the American Dental Association.

TESTS AND PROCEDURES

Diagnostic Services and medical procedures performed by a Doctor, other than Doctor's Visits, Physical Therapy and X-rays and Lab procedures. This includes Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition.

Biomarker Testing

Benefits will be provided for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition.

Pancreatic Cancer Screening

Benefits will be provided for Medically Necessary pancreatic cancer screenings.

Comprehensive Cancer Testing

Benefits will be provided for Medically Necessary comprehensive cancer testing, including, but not limited to, whole-exome genome testing, whole-genome sequencing, RNA sequencing, tumor mutation burden, and targeted cancer gene panels.

Port-Wine Stain Treatment

Benefits for all of the Covered Services previously described under this Policy are available for the treatment to eliminate or provide maximum feasible treatment of nevus flammeus, also known as port-wine stains, including, but not limited to, port-wine stains caused by Sturge-Weber Syndrome. This benefit does not apply to Port-Wine Stain Treatment, solely for cosmetic reasons.

SKILLED NURSING FACILITY

Covered Inpatient Hospital Services and supplies given to an Inpatient of an eligible Skilled Nursing Facility. Subject to the Preauthorization guidelines set forth in this Policy. No Benefits are payable:

- Once the Covered Person can no longer improve from treatment; or
- For Custodial Care, or care for someone's convenience.

No Benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

COORDINATED HOME HEALTH CARE

Includes the following Covered Services the Covered Person receives from a Hospital program for Coordinated Home Health Care, provided such program is an eligible Provider and the care is prescribed by a Physician:

- Medical and surgical supplies;
- Prescribed Drugs; and
- Oxygen and its administration.

Limited to the following:

- Professional services of an RN, LPN, or LVN;
- Medical social service consultations;
- Health aide services while the Covered Person is receiving covered nursing or Therapy Services; and
- Services of a licensed registered dietician or licensed certified nutritionist, when authorized by the patient's supervising Physician and when Medically Necessary as part of diabetes self-management training.

Coordinated Home Health Care is subject to the Preauthorization guidelines set forth in this Policy. No Benefits are payable for:

- Dietician service, except as specified for diabetes self-management training;
- Homemaker services;
- Maintenance Therapy;
- Speech Therapy;
- Durable Medical Equipment;

- Food or home-delivered meals; and
- Intravenous drugs, fluid, or nutritional therapy, except when the Covered Person has received Preauthorization from the Plan for these services.

HOSPICE

Care and services performed under the direction of the Covered Person's attending Physician in an eligible Hospital Hospice Facility or in-home Hospice program. Hospice services are subject to the Preauthorization guidelines set forth in this Policy.

The following services are covered under Hospice Benefits:

- Coordinated Home Care;
- Nursing Services - Skilled and non-Skilled;
- Medical Supplies and dressings;
- Medication;
- Occupational Therapy;
- Pain management services;
- Physical Therapy;
- Physician visits;
- Social and spiritual services; and
- Respite Care Service.

The following services are not covered under Hospice Benefits:

- Durable medical equipment;
- Home delivered meals;
- Homemaker services;
- Traditional medical services provided for the direct care of the terminal illness, disease, or condition; or
- Transportation, including, but not limited to, ambulance service.

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

HUMAN ORGAN TRANSPLANTS

A Covered Person's Benefits for certain human organ transplants are the same as his/her Benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, musculoskeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have Blue Cross and Blue Shield of Illinois coverage each will have their Benefits paid by their own Blue Cross and Blue Shield of Illinois program;
- If a Covered Person is the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the Benefits under this Policy will be provided for both the Covered Person and the donor. In this case, payments made for the donor will be charged against the Covered Person's Benefits; and
- If a Covered Person is the donor for the transplant and no coverage is available to him/her from any other source, the Benefits under this Policy will be provided for him/her. 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; and
- 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 a Covered Person's Physician, he/she must contact Blue Cross and Blue Shield of Illinois by telephone before his/her transplant Surgery has been scheduled. Blue Cross and Blue Shield of Illinois will furnish the Covered person with the name of Hospitals that have a Blue Cross and Blue Shield of Illinois approved Human Organ Transplant Program. No Benefits will be provided for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants performed at any Hospital that does not have a Blue Cross and Blue Shield of Illinois approved Human Organ Transplant Program.
- If a Covered Person is the recipient of the transplant, Benefits will be provided for transportation and lodging for him/her and one or two companions. For Benefits to be available, a Covered Person's place of residency must be more than 50 miles from the Hospital where the transplant will be performed. The maximum amount that will be provided for lodging is $50 per person per day. Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. In addition to other exclusions of this Policy, Benefits will not be provided for the following:
  (a) Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery;
  (b) Transportation by air ambulance for the donor or the recipient;
  (c) Travel time and related expenses required by a Provider;
  (d) Drugs which do not have approval of the Food and Drug Administration;
  (e) Storage fees;
  (f) Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision; and
  (g) Meals.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT

Benefits for all Covered Services described in this Policy are available for Substance Use Disorder Rehabilitation Treatment. In addition, Benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient Benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center. Subject to the Preauthorization, if any, guidelines set forth in this Policy.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this Policy are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorders. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Subject to the Preauthorization guidelines, if any, set forth in this Policy.

EARLY TREATMENT OF A SERIOUS MENTAL ILLNESS

Benefits will be provided to treat a serious mental illness in a child or young adult under age 26, for the following bundled, evidenced-based treatments:

First Episode Psychosis Treatment - benefits for coordinated specialty care for first episode psychosis treatment 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; and

Community Support Team Treatment (CST) - benefits for CST will be covered when provided by DHS-Certified Providers.

In addition to the **DEFINITIONS** in this Policy, the following definitions are applicable to this provision:

DHS-Certified Provider *means* a Provider certified to provide ACT and CST by the Illinois Department of Human Services Division of Mental Health and approved to provide ACT and CST 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 to deliver coordinated specialty care for first episode psychosis treatment.

DETOXIFICATION

Benefits for Covered Services received for detoxification will be covered the same as any other condition.

AUTISM SPECTRUM DISORDER(S)

A Covered Person's Benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as his/her Benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided, or ordered for an individual diagnosed with an Autism Spectrum Disorder by: (1) a Physician or a Psychologist who has determined that such care is Medically Necessary; or (2) a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:

- psychiatric care, including Diagnostic Services;
- psychological assessments and treatments;
- habilitative or rehabilitative treatments;
- therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: (1) self-care and feeding; (2) pragmatic, receptive and expressive language; (3) cognitive functioning; (4) applied behavior analysis (ABA), intervention and modification; (5) motor planning; and (6) sensory processing.

Services may not be denied solely based on the site of treatment.

HABILITATIVE SERVICES AND DEVICES

Benefits for Habilitative Services and Devices for Covered Persons with a Congenital, Genetic, or Early Acquired Disorder are the same as Covered Person's Benefits for any other condition if all of the following conditions are met:

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

Services may not be denied solely based on the site of treatment.

THE PROCESSING, TRANSPORTING, STORING, HANDLING AND ADMINISTRATION OF BLOOD AND BLOOD COMPONENTS.

PRIVATE DUTY NURSING SERVICE

Benefits for Private Duty Nursing Service will be provided to a Covered Person in his/her home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care Provider. No Benefits will be provided when a nurse ordinarily resides in a Covered Person's home or is a member of a Covered Person's Immediate Family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment uses and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available nonprofessional personnel. Benefits for Private Duty Nursing Service are subject to the Preauthorization guidelines set forth in this Policy.

NAPRAPATHIC SERVICE

Benefits will be provided for Naprapathic Services when rendered by a Naprapath.

BARIATRIC SURGERY

Benefits for Covered Services received for Bariatric Surgery will be covered the same as any other condition.

PULMONARY REHABILITATION THERAPY

Benefits will be provided for Outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident.

ROUTINE PEDIATRIC HEARING EXAMINATION

Benefits will be provided for routine hearing examinations for children up to age 19.

HEARING AIDS

Benefits will be provided for Hearing Aids for Covered Persons under the age of 19 when a Hearing Care Professional prescribes a Hearing Aid to augment communication as follows:

- One Hearing Aid will be covered for each ear every 24 months;

- Related services, such as audiological examinations and selection, fitting, and adjustment of ear molds to maintain optimal fit will be covered when deemed Medically Necessary by a Hearing Care Professional; and
- Hearing Aid repairs will be covered when deemed Medically Necessary.

Benefits will be provided for Hearing Aids for Covered Persons aged 19 and over when a Hearing Care Professional prescribes a Hearing Aid to augment communication as follows:

- Benefits up to $2,500 for one Hearing Aid will be covered for each ear every 24 months;
- Related services, such as audiological examinations and selection, fitting, and adjustment of ear molds to maintain optimal fit will be covered when deemed Medically Necessary by a Hearing Care Professional; and
- Hearing Aid repairs will be covered when deemed Medically Necessary.

MAMMOGRAMS

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

- one baseline mammogram; and
- an annual mammogram.

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

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

Benefits for Diagnostic Mammograms will be provided for women when determined to be Medically Necessary by a Physician, Advanced Practice Nurse, or Physician Assistant.

Benefits for mammograms will be provided at 100% of the Allowable Amount, whether you have met your program Deductible. Benefits for mammograms will not be subject to any Benefit Period maximum or lifetime maximum.

MASTECTOMY-RELATED SERVICES

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

- 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 followed 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; and
- The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a Sickness or Injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from Sickness or Injury is not considered cosmetic Surgery.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

TELEHEALTH AND TELEMEDICINE SERVICES

This plan provides Benefits for Medically Necessary Telehealth and Telemedicine Services.

VIRTUAL VISITS

If Virtual Visits are listed in your ***Outline of Coverage***, Benefits will be provided for Covered Services described in this Policy for the diagnosis and treatment of non-emergency medical and behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit. Benefits for Covered Services will only be provided if you receive them via consultation with a Virtual Provider who has a specific written agreement with Blue Cross and Blue Shield of Illinois to provide Virtual Visits to you at the time services are rendered. For more information about this Benefit, you can call the toll-free telephone number on the back of your Identification Card or visit our website at www.bcbsil.com.

Benefits for Covered Services you receive through a Virtual Visit will be provided at the payment level shown in the Medical Benefit Highlights. Benefits will not be provided for services you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with Blue Cross and Blue Shield of Illinois 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.

- Preferred Participating Pharmacies: Although a Covered Person can go to the Pharmacy of a Covered Person's choice, a Covered Person's Benefits for drugs and supplies will be greater when a Covered Person obtains them from a Preferred Participating Pharmacy. Covered Persons can visit the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com for a list of Preferred Participating Pharmacies or call the toll-free telephone number on the back of your Identification Card. The Pharmacies that are Preferred Participating Pharmacies may change from time to time. A Covered Person should check with their Pharmacy before obtaining drugs or supplies to make certain of its participation status.
- Drug List: The Benefit payments of drugs listed on the Drug List are selected by Blue Cross and Blue Shield of Illinois based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with Blue Cross and Blue Shield of Illinois. The committee considers drugs regulated by the FDA for inclusion on the Drug List. As part of the process, the committee reviews data from clinical studies, published literature and opinions from experts who are not part of the committee. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List. The committee considers drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to this list can be made from time to time. Blue Cross and Blue Shield of Illinois may offer multiple Drug Lists. Covered Persons will be able to determine the Drug List that applies to their Policy and whether a particular drug is on the Drug List. Drugs that appear on the Drug List as Non-Preferred Brand Name Drugs are subject to the Non-Preferred Brand Name Drug payment level plus any pricing differences that may apply to the Covered Drug a Covered Person receives. You, your prescribing health care Provider, or your authorized representative, can ask for an exception if your drug is not on (or is being removed from) the Drug List if the drug requires prior authorization before it may be covered or if the drug required as part of step therapy has been found to be (or likely to be) not right for you or does not work as well in treating your condition. To request this exception, you, your prescribing Provider, or your authorized representative, can call the toll- free telephone number on the back of your Identification Card to ask for a review. Blue Cross and Blue Shield of Illinois will let you; your prescribing Provider (or authorized representative) know the coverage decision within 72hours after they receive your request. If the coverage request is denied, Blue Cross and Blue Shield of Illinois will let you and your prescribing Provider (or authorized representative) know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals and external exception review process you receive with the denial determination.
- Prior Authorization: Certain Prescription Drugs require a drug's prescribed use to be evaluated against a predetermined set of criteria to determine Medical Necessity before the prescription will be covered. If the approval is not granted, the Covered Person may appeal the decision.
- Step Therapy: When the Covered Person buys a Prescription Drug which has a more cost-effective option in the same therapeutic class and is recommended by the Pharmacist, coverage will be limited to the cost of the more cost-effective drug.
- Dispensing Limits: If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Professional Provider, coverage will only be provided for a clinically appropriate pre- determined maximum quantity of medication for the specified amount of time.
- Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines. Early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the prescribing Physician or Optometrist.
- Controlled Substance Limitation: If Blue Cross and Blue Shield of Illinois determines that a Covered Person maybe receiving quantities of Controlled Substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary and appropriate and coverage restrictions, which may include but not limited to limiting coverage to services provided by a certain Provider and/or Pharmacy for the prescribing and dispensing of the Controlled Substance medication and/ or limiting coverage to certain quantities. For the purposes of this provision, controlled substance medications are medications classified or restricted by state or federal laws.

- Therapeutic Equivalents: Some drugs are manufactured under multiple brand names and have many therapeutic equivalents. Generic medications may also have several therapeutic equivalents. In such cases, Blue Cross and Blue Shield of Illinois may limit Benefits to specific therapeutic equivalents. If a Covered Person does not choose the therapeutic equivalents that are covered under this Benefit section, the drug purchased will not be covered under any Benefit level.
- If you choose to have a Prescription Order filled or obtain a covered vaccination at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a Claim form with Blue Cross and Blue Shield of Illinois or to your Prescription Drug administrator with itemized receipts verifying that the Prescription Order was filled, or a covered vaccination was provided.
- 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, or on your behalf, that amount will be applied to your Deductible or Out-of-Pocket Maximum.

Prescription Refills

You are entitled to synchronize your Prescription Order 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 Policy 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 by the Illinois Controlled Substances Act;
- all utilization management criteria (as described under the Prior Authorization/Step Therapy requirement provision above) for Prescription Drugs have been met;
- the Prescription Drugs can be safely split into short-fill periods to achieve synchronization; and
- the Prescription Drugs do not have special handling or sourcing needs that require a single, designated Pharmacy to fill or refill the prescription.

When necessary to permit synchronization, Blue Cross and Blue Shield of Illinois will prorate the Copayment or Coinsurance, on a daily basis, due for Covered Drugs based on the proportion of days the reduced Prescription Order covers to the regular day supply as shown in the Outpatient Prescription Drugs Benefit Highlights.

Retail Pharmacy

The Benefits you receive and the amount you pay will differ depending upon the tier and type of drugs, or diabetic supplies or insulin and insulin syringes obtained and whether they are obtained from a Preferred Participating Pharmacy, Participating Pharmacy, or Non-Participating Pharmacy.

When you obtain Covered Drugs (other than Specialty Drugs), including diabetic supplies from a Preferred Participating Pharmacy or Participating Pharmacy, Benefits will be provided as shown in the Outpatient Prescription Drugs Benefit Highlights.

When you obtain Covered Drugs, including diabetic supplies from a Non-Participating Pharmacy (other than a Participating Pharmacy), Benefits will be provided at the percentage amount shown in the Outpatient Prescription Drugs Benefit Highlights that you would have received had you obtained drugs from a Participating Pharmacy Provider, minus the Deductible, if any. If an out-of-pocket expense limit is shown in the Outpatient Prescription Drugs Benefit Highlights for Non-Participating Pharmacy Providers, then the Copayment Amount and Coinsurance Amount will apply towards the out-of-pocket expense limit, if any, for Non-Participating Pharmacy Providers. However, none of your other expenses at such Non-Participating Pharmacy will apply towards the out-of-pocket expense limit.

The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $100, when obtained from a Preferred Participating or Participating Pharmacy.

Specialty Drugs

In order to receive maximum Benefits for Specialty Drugs, a Covered Person must obtain the Specialty Drugs from a preferred Specialty Pharmacy Provider. Specialty Drugs obtained from all other pharmacies will be provided at the

percentage amount shown in the Outpatient Prescription Drugs Benefit Highlights a Covered Person would have received had he/she obtained drugs from a Specialty Pharmacy Provider and will not apply to a Covered Person's Deductible.

Cancer Medications

Benefits will be provided for orally administered cancer medications, or self-injected cancer medications that are used to treat cancer when a particular legend drug has been shown effective for the treatment of that specific type of cancer and if proper documentation is provided, even though that legend drug may not have FDA-approval for that type of cancer. The drug must have been shown to be effective for the treatment of that particular cancer according to the American Hospital Formulary Service Drug Information; National Comprehensive Cancer Network's Drugs & Biologics Compendium; Thomson Micromedex's Drug Dex; Elsevier Gold Standard's Clinical 62 IL_SH_PPO_2021 Pharmacology; or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services. Your Deductible, Copayment Amount or Coinsurance Amount 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 Participating Specialty Pharmacy or Non-Participating Pharmacy will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

Opioid Medically Assisted Treatment

Benefits will be provided for Buprenorphine or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder.

Intranasal Opioid Reversal Agent

Benefits will be provided for at least one intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50MME or higher.

Topical Anti-Inflammatory Acute and Chronic Pain Medication

Benefits will be provided for Topical anti-inflammatory medication, including, but not limited to, Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain.

Injectable Drugs

Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law, including but not limited to epinephrine injectors. Benefits will not be provided under this Benefit section for any self-administered drugs dispensed by a Physician.

Diabetic Supplies for Treatment of Diabetes

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

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

Immunosuppressant Drugs

Benefits are available for immunosuppressive drugs prescribed in connection with a human organ transplant.

Fertility Drugs

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

Opioid Antagonists

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

Vaccinations obtained through Participating Pharmacies

Benefits for vaccinations are available through certain Participating Pharmacies that have contracted with Blue Cross and Blue Shield of Illinois to provide this service. To locate one of these Participating Pharmacies in your area and to find out which vaccinations are covered, call customer service at the toll-free telephone number on the back of your Identification Card for more information or visit Our website at www.bcbsil.com. At the time you receive services, present your Identification Card to the pharmacist. This will identify you as a participant in the Blue Cross and Blue Shield health care plan. The pharmacist will inform you of the amount for which you are responsible for, if any.

Each Participating Pharmacy that has contracted with Blue Cross and Blue Shield of Illinois to provide this service may have age, scheduling, or other requirements that will apply, so Covered Persons are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under the ***Outpatient Prescription Drug Program***. A Covered Person can refer to his/her Blue Cross and Blue Shield of Illinois medical coverage for Benefits available for childhood immunizations.

Benefits for select 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 an In-Network Provider or Participating Pharmacy that is contracted for such service.

Vaccinations that are received from an Out-of-Network Provider, Non-Participating Pharmacy or from a Non-Plan Provider facility or out-of-network pharmacists, or other routine Covered Services not provided for under this provision may be subject to the Deductible, Coinsurance, Copayment and/or Benefit maximums.

Long-term Antibiotic Therapy

Benefits will be provided for 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.

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 drug has been approved by the United States Food and Drug Administration.

Split Fill Program

If this is your first time using select medications (e.g., oral cancer medications) or 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. Your cost-share may be adjusted to align with the number of pills dispensed. If the medication is working for you and your Physician 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.

Notice of Certain Mandatory Benefits

This notice is to advise the Policyholder of certain coverages/Benefits provided by your Policy with Blue Cross and Blue Shield of Illinois.

Cancer Clinical Trials Benefit

Benefits will be provided for routine patient care in conjunction with investigational treatments when medically appropriate and a Covered Person has a terminal condition that according to the diagnosis of a Covered Person's Physician is considered a Life Threatening Disease or Condition if a) a Covered Person is a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this Policy if not provided in connection with an Approved Clinical Trial program. Blue Cross and Blue Shield of Illinois will not terminate or non-renew a Student's coverage under this Policy due to participation in an Approved Clinical Trial program. A Covered Person and his/her Physician are encouraged to call the toll-free telephone number on the back of their Identification Card in advance to obtain information about whether a particular clinical trial is qualified. Benefits for expenses covered under this provision will be subject to all of the terms and conditions of the group health Policy notwithstanding and payable to the same extent as any other medical expenses covered by the group Policy.

Other Reproductive Health Services

Your coverage includes Benefits for abortion care. Benefits for abortion care are the same as your Benefits for any other condition, in the Medical Benefit Highlights for each service or place of treatment.

Preventive Care Services

In addition to the Benefits otherwise provided for in this Policy, (and notwithstanding anything in this Policy to the contrary), the following Benefits for preventive care services will be considered Covered Services and will not be subject to any Deductible, Coinsurance, Copayment or dollar maximum (to be implemented in the quantities and within the time period allowed under Applicable Law or regulatory guidance) when such services are received from an In-Network Provider or a Participating Pharmacy that is contracted for such service:

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
3. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
4. with respect to women, such additional preventive care, and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the member.

If an In-Network Provider recommends services or labs during a preventive care visit that do not meet the criteria stated above, Covered Services may be subject to a Deductible, Coinsurance, Copayment, or dollar maximum.

For purposes of this preventive care services Benefit provision, the current recommendations of the USPSTF regarding breast cancer screening, mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, Covered Persons can call the toll-free telephone number on the back of their Identification Card or visit Our website at www.bcbsil.com.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, Blue Cross and Blue Shield of Illinois may use reasonable medical management techniques to determine coverage.

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

- Abdominal aortic aneurysm screening for men ages 65-75 who have ever smoked;
- Unhealthy Alcohol and drug use screening and counseling;
- Aspirin use for men and women for prevention of cardiovascular disease for certain ages;
- Blood pressure screening;
- Cholesterol screening for adults of certain ages or at higher risk;
- Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions;
- Colorectal cancer screening for adults over age 45, and a follow-up colonoscopy if the results of the initial test or procedure is abnormal;
- Depression screening;
- Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease;
- HIV screening for all adults at higher risk;
- HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition;
- The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
  (1) Hepatitis A
  (2) Hepatitis B
  (3) Herpes Zoster (Shingles)
  (4) Human papillomavirus
  (5) Influenza (Flu shot)
  (6) Measles, Mumps, Rubella
  (7) Meningococcal
  (8) Pneumococcal
  (9) Tetanus, Diphtheria, Pertussis
  (10) Varicella
- Obesity screening and counseling;
- Sexually transmitted infections (STI) prevention;
- Tobacco use screening and cessation interventions for tobacco users;
- Syphilis screening for adults at higher risk;
- Exercise interventions to prevent falls in adults aged 65 years and older who are at increased risk for falls;
- Hepatitis C virus (HCV) screening for infection in adults aged 19 to 79 years;
- Hepatitis B virus screening for persons at high risk for infection;
- Counseling children, adolescents, and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
- Lung cancer screening in adults 50 and older who have a 20-pack year smoking history and currently smoke or have quit within the past 15 years;
- Screening for high blood pressure in adults aged 18 years or older;
- Screening for abnormal blood glucose and type II diabetes mellitus as part of cardiovascular risk assessment in adults who are overweight or obese;
- Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history of CVD, (b) or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking), and (c) a calculated 10-year CVD risk of 10% or greater;

- Tuberculin testing for adults 18 years or older who are at a higher risk of tuberculosis; and
- Whole body skin examination for lesions suspicious for skin cancer.

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

- Bacteriuria urinary tract screening or other infection screening for pregnant women;
- BRCA counseling about genetic testing for women at higher risk;
- Breast cancer mammography screenings, including breast tomosynthesis and, if determined to be Medically Necessary by a Physician, Advanced Practice Nurse, or a Physician Assistant, a screening MRI and comprehensive ultrasound;
- Clinical Breast Exam;
- Breast cancer chemoprevention counseling for women at higher risk;
- Breastfeeding comprehensive lactation support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Electric breast pumps are limited to 1 per Benefit Period;
- Cervical cancer screening;
- Chlamydia infection screening for younger women and women at higher risk;
- Contraception: Certain FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling;
- Domestic and interpersonal violence screening and counseling for all women;
- Diabetes mellitus screening after pregnancy;
- Daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant;
- Gestational diabetes screening for women after 24 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea screening for all women;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- HIV screening and counseling for women and pre-natal HIV testing;
- Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older;
- Osteoporosis screening for women over age 60, depending on risk factors;
- Perinatal depression screening and counseling;
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users;
- Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have recently been screened;
- Sexually transmitted infections (STI) counseling for women;
- Syphilis screening for all pregnant women or other women at increased risk;
- Well-woman visits to obtain recommended preventive services;
- Urinary incontinence screening;
- Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal;
- Aspirin use for pregnant women to prevent preeclampsia; and
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

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

- Alcohol and drug use assessment for adolescents;
- Behavioral assessments for children of all ages;
- Blood pressure screenings for children of all ages;
- Cervical dysplasia screening for females;
- Congenital hypothyroidism screening for newborns;

- Critical congenital heart defect screening for newborns;
- Major depression disorder (MDD) screening for adolescents;
- Development screening for children under age 3, and surveillance throughout childhood;
- Dyslipidemia screening for children at higher risk of lipid disorder;
- Bilirubin screenings in newborns;
- Fluoride chemoprevention supplements for children without fluoride in their water source;
- Fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing screening for all newborns, children, and adolescents;
- Height, weight, and body mass index measurements;
- Hematocrit or hemoglobin screening;
- Hemoglobinopathies or sickle cell screening for all newborns;
- HIV screening for adolescents at higher risk;
- The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
  (1) Diphtheria, Tetanus, and Acellular Pertussis;
  (2) Haemophilus influenzae type b (Hib);
  (3) Hepatitis A;
  (4) Hepatitis B;
  (5) Human papillomavirus (HPV);
  (6) Inactivated Poliovirus;
  (7) Influenza (Flu shot);
  (8) Measles, Mumps, Rubella;
  (9) Meningococcal;
  (10) Pneumococcal;
  (11) Rotavirus; and
  (12) Varicella.
- Lead screening for Children at risk for exposure;
- Autism screening for Children at 18-24 months of age;
- Medical history for all Children throughout development;
- Obesity screening and counseling;
- Oral health risk assessment for younger Children up to six years old;
- Phenylketonuria (PKU) screening for newborns;
- Sexually transmitted infections (STI) prevention and counseling for adolescents;
- Tuberculin testing for Children at higher risk of tuberculosis;
- Vision screening for all Children and adolescents;
- Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school aged Children and adolescents;
- Newborn blood screening;
- Any other immunization that is required by law for a Child. Allergy injections are not considered immunizations under this Benefit provision; and
- Whole body skin examination for lesions suspicious for skin cancer.

Drugs (including both prescription and over the counter) that fall within a category of the current "A" or "B" recommendations of the United States Preventive Services Task Force and that are listed on the ACA Preventive Services Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the Preventive Services Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount,

Deductibles, or dollar maximums, if applicable.

The FDA approved contraceptive drugs and devices currently covered under this Benefit provision are listed on the *Women's Contraceptive Coverage List.* This list is available on Our website at www.bcbsil.com and by contacting customer service at the toll-free telephone number on the back of your Identification Card. Benefits are not available under this Benefit provision for Contraceptive drugs and devices not listed on the *Women's Contraceptive Coverage List*. A Covered Person may, however, have coverage under other sections of this Policy, subject to any applicable Coinsurance, Copayments, Deductibles and/or Benefit maximum. The *Women's Contraceptive Coverage List* and the preventive care services covered under this Benefit provision are subject to change as FDA guidelines, medical management, and medical policies are modified.

Routine pediatric care, women's preventive care (such as contraceptives) and/or Outpatient periodic health examinations Covered Services not included above will be subject to the Deductible, Coinsurance, Copayments and/or Benefit maximums previously described in this Policy, if applicable.

Preventive care services received from an Out-of-Network 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 maximums.

If a Covered Person's plan covers Well Child Care, Women's Preventive Care (such as contraceptives) and/or Wellness Care, Covered Services not included above will be subject to Deductible, Coinsurance, Copayment and/or dollar maximum, if applicable.

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

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

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

Coordination of Benefits

Coordination of Benefits (COB) applies to this Benefit program when the Covered Person has health care coverage under more than one Benefit program. COB does not apply to the ***Outpatient Prescription Drug Program*** Benefit section or the ***Pediatric Vision Care*** provision.

The order of Benefit determination rules should be looked at first. Those rules determine whether the Benefits of this Benefit Program are determined before or after those Benefits of another Benefit Program. The Benefits of this Benefit Program:

- Shall not be reduced when, under the order of Benefit determination rules, this Benefit Program determines its Benefits before another Benefit Program; but
- May be reduced when, under the order of Benefits determination rules, another Benefit Program determines its Benefits first. This reduction is described below in "When this Benefit Program is a Secondary Program."

In addition to the ***Definitions*** section of this Policy, the following definitions apply to this section:

ALLOWABLE EXPENSE means a Covered Expense when the Covered Expense is covered at least in part by one or more Benefit Program covering the person for whom the Claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under this definition unless the Covered Person's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Benefit Program.

When a Benefit Program provides Benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a Benefit paid.

BENEFIT PROGRAM means any of the following that provides Benefits or services for, or because of, medical or dental care or treatment:

- Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental plan, or coverage required or provided bylaw. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

Each contract or other arrangement under (i) or (ii) above is a separate Benefit program. Also, if an arrangement has two parts and COB rules apply only to one of the two above, each of the parts is a separate Benefit Program.

CLAIM DETERMINATION PERIOD means a Benefit Period. However, it does not include any part of a year during which a person has no coverage under this Benefit Program, or any part of a year before the date this COB provision or a similar provision takes effect.

PRIMARY PROGRAM or SECONDARY PROGRAM means the order of payment responsibility as determined by the order of Benefit determination rules.

When this Benefit Program is the Primary Program, its Benefits are determined before those of the other Benefit Program and without considering the other program's Benefits.

When this Benefit Program is a Secondary Program, its Benefits are determined after those of the other Benefit Program and may be reduced because of the other program's Benefits.

When there are more than two Benefit Programs covering the person, this Benefit Program may be a Primary Program as to one or more other programs and may be a Secondary Program as to a different program or programs.

ORDER OF BENEFIT DETERMINATION

When there is a basis for a Claim under this Benefit Program and another Benefit Program, this Benefit Program is a Secondary Program that has its Benefits determined after those of the other program, unless:

- The other Benefit Program has rules coordinating its Benefits with those of this Benefit Program; and
- Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's Benefits be determined before those of the other Benefit Program.

This Benefit Program determines its order of Benefit payments using the first of the following rules that apply:

1. Non-Dependent or Dependent

The Benefits of the Benefit Program that covers the person as an employee, member, or subscriber (that is, other than a Dependent) are determined before those of the Benefit Program that covers the person as Dependent, except that, if the person is also a Medicare beneficiary, Medicare is:

- Secondary to the Benefit Program covering the person as a Dependent; and
- Primary to the Benefit Program covering the person other than a Dependent, for example a retired employee.

2. Dependent Child if Parents not Separated, Divorced or Civil Union dissolved

Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a Dependent of different persons, (i.e., "parent"):

- The Benefits of the program of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the program of the parent whose birthday falls later in that year; but
- If both parents have the same birthday, the Benefits of the Benefit Program that covered the parent longer are determined before those of the Benefit Program that covered the other parent for a shorter period of time.

However, if the other Benefit Program does not have this birthday-type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of Benefits, the rule in the other Benefit Program will determine the order of Benefits.

3. Dependent Child if Parents Separated, Divorced or Civil Union dissolved

If two or more Benefit Programs cover a person as a Dependent child of divorced or separate parents, Benefits for the child are determined in this order:

- First, the program of the parent with custody of the child;
- Then, the program of the spouse of the parent with custody of the child; and
- Finally, the program of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the Benefits of the program of that parent has actual knowledge of those terms, the Benefits of that program are determined first. The program of the other parent shall be the Secondary Program. This does not apply with respect to any Claim Determination Period or Benefit Program year during which any Benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming Benefits to notify Blue Cross and Blue Shield of Illinois and, upon its request, to provide a copy of the court decree.

4. Dependent Child if Parents Share Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Benefit Programs covering the child shall follow the order of Benefit determination rules outlined in 2 above.

5. Young Adult as a Dependent

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, rule 8, "Length of Coverage" applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of Benefits shall be determined by applying the birthday rule of rule 2 to the Dependent child's parent or parents and the Dependent's spouse.

6. Active or Inactive Employee

The Benefits of a Benefit Program that covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Benefit Program that covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of Benefits, this rule shall not apply.

7. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Benefit Program, the following shall be the order of Benefit determination:

- First, the Benefits of a Benefit Program covering the person as an employee, member, or subscriber (or as that person's Dependent);
- Second, the Benefits under the continuation coverage.

If the other Benefit Program does not contain the order of Benefits determination described within this section, and if, as a result, the programs do not agree on the order of Benefits, this requirement shall be ignored.

8. Length of Coverage

If none of the rules in this section determines the order of Benefits, the Benefits of the Benefit Program that covered an employee, member or subscriber longer are determined before those of the Benefit Program that covered that person for the shorter term.

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

In the event this Benefit Program is a Secondary Program as to one or more other Benefit Programs, the Benefits of this Benefit Program may be reduced.

The Benefits of this Benefit Program will be reduced when:

- The Benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
- The Benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a Claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the Benefits of this Benefit Program will be reduced so that they and the Benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

When the Benefits of this Benefit Program are reduced as described, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of this Benefit Program.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Benefit Program must give Us any facts it needs to pay the Claim.

FACILITY OF PAYMENT

A payment made under another Benefit Program may include an amount that should have been paid under this Benefit Program. If it does, We may pay that amount to the organization that made the payment under the other Benefit Program. That amount will then be treated as though it were a Benefit paid under this Benefit Program. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

RIGHT OF RECOVERY

If the number of payments made by Us is more than it should have paid under this COB provision, we may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations.

The "amount of payments made" includes the reasonable cash value of any Benefits provided in the form of services.

Claim Provisions

Notice of Claim: Written notice of claim must be given to the company within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the company at the designated location, or to any authorized agent of the company, with information sufficient to identify the Insured, shall be deemed notice to the company.

Claim Forms: The company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss: Written proof of loss must be furnished to the company at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time for Payment of Claim: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Indemnity for loss of life will be payable in accordance with the beneficiary designation and provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

Non-Duplication Of Benefits Limitation: If Benefits are payable under more than one (1) Benefit provision contained in the Policy, Benefits will be payable only under the provision providing the greater Benefit.

Payment to Possessory or Managing Conservator of Dependent Child

For a minor child who otherwise qualifies as a Dependent of the Insured Student, Benefits may be paid on behalf of the child to a person who is not the Insured Student if an order issued by a court of competent jurisdiction in this or any other state names such person the possessory or managing conservator of the child.

To be entitled to receive Benefits, a possessory or managing conservator of a child must submit, to the Insurer, with the Claim form, written notice that such person is the possessory or managing conservator of the child on whose behalf the Claim is made and submit a certified copy of a court order establishing the person as the possessory or managing conservator. This will not apply in the case of any unpaid medical bills for which a valid assignment of Benefits has been exercised or to Claims submitted by the Insured Student where the Insured Student had paid any portion of a medical bill that would be covered under terms of this Policy.

Initial Claims Determinations

Blue Cross and Blue Shield of Illinois will usually process all Claims according to the terms of the Benefit program within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield of Illinois does not process a Claim within this 30-day period, the Covered Person or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. Blue Cross and Blue Shield of Illinois will usually notify the Covered Person, the Covered Person's valid assignee, or the Covered Person's authorized representative when all information required to process a Claim in accordance with the terms of the Benefit program within 30 days of the Claim's receipt has not been received. If the Covered Person fails to follow the procedures for filing a pre-service Claim (as defined below), the Covered Person will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical Claim as defined below). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If the Claim for Benefits is denied, the Covered Person will receive a notice from Blue Cross and Blue Shield of Illinois within the following time limits:

- For Benefit determinations relating to care that is being received at the same time as the determination, such will be provided no later than 72 hours after receipt of the Covered Person's Claim for Benefits; and
- For Benefit determinations relating to urgent care/expedited clinical Claim (as defined below), such notice will be provided no later than 24 hours after the receipt of the Covered Person's Claim for Benefits, unless the Covered Person fail to provide sufficient information. The Covered Person will be notified of the missing information and will have no less than 48 hours to provide the information. A Benefit determination will be made within 48 hours after the missing information is received.

An "urgent care/expedited clinical Claim" is any pre-service Claim for Benefits for Medical Care treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

- For non-urgent pre-service Claims, within 15 days after receipt of the Claim by Blue Cross and Blue Shield of Illinois. A "pre-service Claim" is a non-urgent request for approval that Blue Cross and Blue Shield of Illinois requires the Covered Person to obtain before the Covered Person gets Medical Care, such as Preauthorization or a decision on whether a treatment or procedure is Medically Necessary.
- For post-service Claims, within 30 days after receipt of the Claim by Blue Cross and Blue Shield of Illinois. A "post-service Claim" is a Claim as defined in the ***Definitions*** section.

If Blue Cross and Blue Shield of Illinois determines that special circumstances require an extension of time for processing the Claim, for non-urgent pre-service and post-service Claims, Blue Cross and Blue Shield of Illinois shall notify the Covered Person or the Covered Person's authorized representative in writing of the need for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from the Covered Person, the notice of extension shall also specifically describe the missing information, and the Covered Person shall have at least 45 days from receipt of the notice within which to provide the requested information.

If the Claim for Benefits is denied, the Covered Person or the Covered Person's authorized representative shall be notified in writing of the following:

- The reasons for denial;
- A reference to the Benefit plan provisions on which the denial is based;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis codes with their meanings and the standards used are also available;
- An explanation of Blue Cross and Blue Shield of Illinois's internal review/appeals and external review processes (and how to initiate a review/appeal or external review); Specifically, this explanation will include:
    1. An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);
    2. An explanation that you may ask for an external review with an Independent Review Organization (IRO) not associated with Blue Cross and Blue Shield of Illinois and if your appeal was denied based on any of the reasons below. You may also ask for external review if Blue Cross and Blue Shield of Illinois failed to give you a timely decision (see 4. below), and your Claim was denied for one of these reasons:
        (a) A decision about the medical need for or the experimental status of a recommended treatment;
        (b) A condition was considered pre-existing;
        (c) Your health care coverage was Rescinded. For additional information, see "**Rescission of Coverage**" in the ***General Provisions*** section; or

(d) To ask for an external review, complete the request for External Review form that will be provided to you as part of this notice and available at insurance.illinois.gov/external review and submit it to the Department of Insurance at the address shown below for external reviews.

3. An explanation that you may ask for an expedited (urgent) external review if:
   (a) Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health, or ability to regain maximum function;
   (b) Blue Cross and Blue Shield of Illinois failed to give you a decision within 48 hours of your request for an expedited appeal; or
   (c) The request for treatment is experimental or investigational and your health care Provider states in writing that the treatment would be much less effective if not promptly started;
4. If the written notice is for a Final Adverse Determination, the notice will include an explanation that you may ask for an expedited (urgent) external review if the Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the Covered Person received Emergency Services, but has not been discharged from a facility;
5. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield of Illinois sends you a written decision for appeals that need medical review within 15 business days after we receive any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. Decisions on expedited appeals are considered timely if Blue Cross and Blue Shield of Illinois sends you a written decision within 48 hours of your request for an expedited appeal;
6. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield of Illinois;
7. In certain situations, a statement in non-English language(s) that future written notices of Claim denials and certain other Benefit information may be available (upon request) in such non-English language(s);
8. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claim for Benefits;
9. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
10. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
11. In the case of a denial of an urgent care/expedited clinical Claim a description of the expedited review procedure applicable to such Claims. An urgent care/expedited Claim decision may be provided orally, so long as written notice is furnished to the claimant within 3 days of oral notification; and
12. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For complaints and general inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, IL 62767

Toll-free: (877) 527-9431
Fax: (217) 558-2083

DOI.Complaints@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington Street 4th Floor
Springfield, IL 62767
Toll-free: (877) 850-4740
Fax: (217) 557-8495

DOI.externalreview@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Inquiries and Complaints

An **Inquiry** is a general request for information regarding Claims, Benefits, or membership.

A **Complaint** is an expression of dissatisfaction by the Covered Person either orally or in writing.

Blue Cross and Blue Shield of Illinois has a team available to assist the Covered Person with Inquiries and Complaints. Issues may include, but are not limited to the following:

- Claims; and
- Quality of care.

When the Covered Person's Complaint relates to the dissatisfaction with a Claim denial (or partial denial), then the Covered Person have the right to a Claim review/appeal as described in the ***Claim Appeal Procedures***.

To pursue an Inquiry or Complaint, the Covered Person may call the toll-free telephone number on the back of their Identification Card, or the Covered Person may write to:

Blue Cross and Blue Shield of Illinois
P.O. Box 2401
Chicago, IL 60690-1364

When the Covered Person contacts customer service to pursue an Inquiry or Complaint, the Covered Person will receive a written acknowledgement of the Covered Person's call or correspondence. the Covered Person will receive a written response to the Covered Person's Inquiry or Complaint within 30 days of receipt by customer service. Sometimes the acknowledgement and the response will be combined. If Blue Cross and Blue Shield of Illinois needs more information, the Covered Person will be contacted. If a response to the Covered Person's Inquiry or Complaint will be delayed due to the need for additional information the Covered Person will be contacted.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by Blue Cross and Blue Shield of Illinois, its employees, or a Plan Provider.

Claim Appeal Procedures - Definitions

An appeal of an Adverse Benefit Determination may be filed by the Covered Person, or a person authorized to act the Covered Person's behalf. In some circumstances, a health care Provider may appeal on his/her own behalf. The Covered Person's designation of a representative must be in writing as it is necessary to protect against disclosure of information about the Covered Person except to the Covered Person's authorized representative. To obtain an Authorized Representative Form, the Covered Person or the Covered Person's representative may call the toll-free telephone number on the back of their Identification Card.

An **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make payment for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a Benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by Blue Cross and Blue Shield of Illinois and Blue Cross and Blue Shield of Illinois reduces or terminates such treatment (other than by amendment or termination of the Student's Benefit plan) before the end of the approved treatment period, which is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination.

An **Adverse Determination** means:

- A determination by Blue Cross and Blue Shield of Illinois or its designated utilization review organization that an admission, availability of care, continued stay, or other healthcare service that is a Covered Service has been reviewed and, based upon the information provided, does not meet Blue Cross and Blue Shield of Illinois's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated;
- The denial, reduction or termination or failure to provide or make payment, in whole or in part, for a Benefit based on a determination by Blue Cross and Blue Shield of Illinois or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or
- A Rescission. For additional information, see "**Rescission of Coverage**" in the ***General Provisions*** section.

A **Final Internal Adverse Benefit Determination** means an Adverse Benefit Determination that has been upheld by Blue Cross and Blue Shield of Illinois at the completion of the Blue Cross and Blue Shield of Illinois's internal review/appeal process.

Claim Appeal Procedures

If the Covered Person has received an Adverse Benefit Determination, the Covered Person may have the Covered Person's Claim reviewed on appeal. Blue Cross and Blue Shield of Illinois will review its decision in accordance with the following procedures. The following review procedures will also be used for Blue Cross and Blue Shield of Illinois

(1) coverage determinations that are related to non-urgent care that the Covered Person have not yet received if approval by the Covered Person's plan is a condition of the Covered Person's opportunity to maximum the Covered Person's Benefits and (2) coverage determinations that are related to care that the Covered Person is receiving at the same time as the determination. Claim reviews are commonly referred to as "appeals."

An appeal of an Adverse Benefit Determination may be filed by the Covered Person, or a person authorized to act on the Covered Person's behalf. In some circumstances, a health care Provider may appeal on his/her own behalf. Under the Covered Person's Health Benefit Plan, there is one level of internal appeal available to the Covered Person. The Covered Person's designation of a representative must be in writing as it is necessary to protect against disclosure of information about the Covered Person except to the Covered Person's authorized representative. To obtain an Authorized Representative Form, the Covered Person or the Covered Person's representative may call the toll-free telephone number on the back of their Identification Card. In urgent care situations, a doctor may act as the Covered Person's authorized representative without completing the form.

Within 180 days after the Covered Person receives notice of an Adverse Benefit Determination, the Covered Person may call or write to Blue Cross and Blue Shield of Illinois to request a Claim review. Blue Cross and Blue Shield of Illinois will need to know the reasons why the Covered Person does not agree with the Adverse Benefit Determination.

In support of the Covered Person's Claim review, the Covered Person has the option of presenting evidence and testimony to Blue Cross and Blue Shield of Illinois. The Covered Person and the Covered Person's authorized representative may ask to review the Covered Person's file and any relevant documents and may submit written issues, comments, and additional medical information within 180 days after the Covered Person receives notice of an Adverse Benefit Determination or at any time during the Claim review process.

To contact Blue Cross and Blue Shield of Illinois to request a Claim review or appeal an Adverse Benefit Determination, use the following contact information, or call the toll-free telephone number on the back of your Identification Card:

Claim Review Section

Blue Cross and Blue Shield of Illinois
P.O. Box 2401 Chicago, IL 60690-1364
Toll-free: 1-800-538-8833
Fax: 1-888-235-2936

Fax number for Urgent requests: 1-918-551-2011

Or you can send a secure email by using our message center by logging into Blue Access for Members℠ (BAM) at www.bcbsil.com.

During the course of the Covered Person's internal appeal(s), Blue Cross and Blue Shield of Illinois will provide the Covered Person or the Covered Person's authorized representative (free of charge) with any new or additional evidence considered, relied upon, or generated by Blue Cross and Blue Shield of Illinois in connection with the appealed Claim, as well as any new or additional rationale for a denial at the internal appeals stage.

Such new or additional evidence or rationale will be provided to the Covered Person or the Covered Person's authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give the Covered Person a reasonable opportunity to respond. Blue Cross and Blue Shield of Illinois may extend the time period described in this Policy for its final decision on appeal to provide the Covered Person with a reasonable opportunity to respond to such new or additional evidence or rationale. The appeal will be conducted by individuals associated with Blue Cross and Blue Shield of Illinois and/or by external advisors, but who were not involved in making the initial denial of the Covered Person's Claim. No deference will be given to the initial Adverse Benefit Determination. Before the Covered Person or the Covered Person's 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, must file an appeal or appeals and the appeals must be finally decided by Blue Cross and Blue Shield of Illinois.

Urgent Care/Expedited Clinical Appeals

If the Covered Person's appeal relates to an urgent care/expedited clinical Claim, or health care services, including, but not limited to, procedures or treatments ordered by a health care Provider, the denial of which could significantly increase the risk to the claimant's health, then the Covered Person may be entitled to an appeal on an expedited basis. Before authorization of Benefits for an ongoing course of treatment is terminated or reduced, Blue Cross and Blue Shield of Illinois will provide the Covered Person with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, Blue Cross and Blue Shield of Illinois will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. Blue Cross and Blue Shield of Illinois shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by Blue Cross and Blue Shield of Illinois.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal Blue Cross and Blue Shield of Illinois shall rendered a determination of the appeal within 3 business days if additional information is needed to review the appeal.

Additional information must be submitted within 5 days of the request. Blue Cross and Blue Shield of Illinois shall render a determination of the appeal within 15 business days after it receives the requested information but in no event more than 30 days after the appeal has been received by Blue Cross and Blue Shield of Illinois.

If the Covered Person Needs Assistance

If the Covered Person has any questions about the Claims procedures or the review procedure, the Covered Person can write or call Blue Cross and Blue Shield of Illinois's Headquarters at 1-800-538-8833. Blue Cross and Blue Shield of Illinois offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
P.O. Box 2401
Chicago, IL 60690-1364

If the Covered Person needs assistance with the internal Claims and appeals or the external review processes that are described below, the Covered Person may contact the health insurance consumer assistance office or ombudsman. The Covered Person may contact the Illinois ombudsman program at 1-877-527-9431 or call the toll- free telephone number on the back of their Identification Card for contact information.

Notice of Appeal Determination

Blue Cross and Blue Shield of Illinois will notify the party filing the appeal, the Covered Person, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal.

The written notice will include:

- The reasons for the determination;
- A reference to the Benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment and denial codes with their meanings and the standards used are also available; and

- An explanation of Blue Cross and Blue Shield of Illinois's external review processes (and how to initiate an external review); Specifically, this explanation will include:
  (1) An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);
  (2) An explanation that you may ask for an external review with an Independent Review Organization (IRO) not associated with Blue Cross and Blue Shield of Illinois and if your appeal was denied based on any of the reasons below. You may also ask for external review if BCBSIL failed to give you a timely decision (see 4. below), and your Claim was denied for one of these reasons:
     (a) A decision about the medical need for or the experimental status of a recommended treatment;
     (b) Your health care coverage was Rescinded. For additional information, see the definition of Rescission in under the Definitions section of under this Policy.
  (3) To ask for an external review, complete the request for External Review form that will be provided to you as part of this notice and available at insurance.illinois.gov/external review and submit it to the Department of Insurance at the address shown below for external reviews;
  (4) An explanation that you may ask for an expedited (urgent) external review if:
     (a) Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health, or ability to regain maximum function;
     (b) Blue Cross and Blue Shield of Illinois failed to give you a decision within 48 hours of your request for an expedited appeal; or
     (c) The request for treatment is experimental or investigational and your health care Provider states in writing that the treatment would be much less effective if not promptly started;
  (5) The Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which the Covered Person received Emergency Services, but has not been discharged from a facility. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield of Illinois sends you a written decision for appeals that need medical review within 15 business days after we receive any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. Decisions on expedited appeals are considered timely if Blue Cross and Blue Shield of Illinois sends you a written decision within 48 hours of your request for an expedited appeal;
  (6) In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other Benefit information may be available (upon request) in such non-English language(s);
  (7) In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield of Illinois;
  (8) The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claim for Benefits;
  (9) Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
  (10) An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and
  (11) A description of the standard that was used in denying the Claim and a discussion of the decision.

If Blue Cross and Blue Shield of Illinois's decision is to continue to deny or partially deny the Covered Person's Claim or the Covered Person does not receive a timely decision, the Covered Person may be able to request an external review of the Covered Person's Claim by an independent third party, who will review the denial and issue a final decision. The Covered Person's external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below.

If an appeal is not resolved to the Covered Person's satisfaction, the Covered Person may appeal Blue Cross and Blue Shield of Illinois's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify Blue Cross and Blue Shield of Illinois of the appeal. Blue Cross and Blue Shield of Illinois will have 21 days to respond to the Illinois Department of Insurance.

The operations of Blue Cross and Blue Shield of Illinois are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent the Covered Person from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

The Illinois Department of Insurance can be contacted at:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit

320 West Washington Street 4th Floor
Springfield, IL 62767

Toll-free: (877) 527-9431
Fax: (217) 558-2083

DOI.externalreview@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit

320 West Washington Street 4th Floor
Springfield, IL 62767

Toll-free: (877) 850-4740
Fax: (217) 557-8495

DOI.externalreview@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

The Covered Person must exercise the right to internal appeal as a precondition to taking any action against Blue Cross and Blue Shield of Illinois, either at law or in equity. If the Covered Person has an adverse appeal determination, the Covered Person may file civil action in a state or federal court.

Independent External Review

The Covered Person or the Covered Person's authorized representative may make a request for a standard external or expedited external review of an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

An **"Adverse Determination"** means a determination by Blue Cross and Blue Shield of Illinois or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet Blue Cross and Blue Shield of Illinois's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

A **"Final Adverse Determination"** means an Adverse Determination involving a Covered Service that has been upheld by Blue Cross and Blue Shield of Illinois or its designated utilization review organization, at the completion of Blue Cross and Blue Shield of Illinois's internal grievance process procedures.

1. Standard External Review

The Covered Person or the Covered Person's authorized representative must submit a written request for an external independent review within four months of receiving an Adverse Determination or Final Adverse Determination. Your request should be submitted to the Illinois Department of Insurance at the following address:

Illinois Department of Insurance Office of Consumer Health
Insurance External Review Unit
320 West Washington Street 4th Floor
Springfield, IL 62767

Toll-free phone (877) 850-4740
Fax number (217) 557-8495

Doi.externalreview@illinois.gov
Email address https://mc.insurance.illinois.gov/messagecenter.nsf

The Covered Person may submit additional information or documentation to support the Covered Person's request for the health care services.

Preliminary Review. Within 5 business days of receipt of the Covered Person's request, Blue Cross and Blue Shield of Illinois will complete a preliminary review of the Covered Person's request to determine whether:

- the Covered Person was covered at the time health care service was requested or provided;
- The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this Benefit program, but Blue Cross and Blue Shield of Illinois has determined that the health care service does not meet Blue Cross and Blue Shield of Illinois's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness;
- the Covered Person has exhausted Blue Cross and Blue Shield of Illinois's internal grievance process (in certain urgent cases, the Covered Person may be eligible for expedited external review even if the Covered Person has not filed an internal appeal with Blue Cross and Blue Shield of Illinois, and , the Covered Person may also be eligible for external review if the Covered Person filed an internal appeal but have not received a decision from Blue Cross and Blue Shield of Illinois within 15 days after Blue Cross and Blue Shield of Illinois received all required information or within 48 hours if the Covered Person has filed a request for an expedited internal appeal); and
- the Covered Person has provided all the information and forms required to process an external review.

For external reviews relating to a determination based on treatment being Experimental or Investigational, Blue Cross and Blue Shield of Illinois will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Blue Cross and Blue Shield of Illinois's determination that the service or treatment is Experimental or Investigational for a particular medical condition and is not explicitly listed as an excluded Benefit. In addition, the Physician who ordered or provided the services in question has certified that one of the following situations is applicable:

- Standard health care services or treatments have not been effective in improving the Covered Person's condition;
- Standard health care services or treatments are not medically appropriate for the Covered Person;
- There is no available standard health care services or treatment covered by Blue Cross and Blue Shield of Illinois that is more beneficial than the recommended or requested service or treatment;
- The health care service or treatment is likely to be more beneficial to the Covered Person, in the opinion of the Covered Person's health care Provider, than any available standard health care services or treatments; or
- That scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to the Covered Person than any available standard health care services or treatments.

Notification. Within one business day after completion of the preliminary review, Blue Cross and Blue Shield of Illinois shall notify the Covered Person and the Covered Person's authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the Covered Person shall be notified by Blue Cross and Blue Shield of Illinois in writing of what materials are required to make the request complete or the reason for its ineligibility. Blue Cross and Blue Shield of Illinois's determination that the external review request is ineligible for review maybe appealed to the Illinois Department of Insurance ("IDOI") by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the IDOI's decision shall be in accordance with the terms of the Covered Person's Benefit program and shall be subject to all Applicable Laws or regulatory guidance, as appropriate.

Assignment of IRO. If the Covered Person's request is eligible for external review, Blue Cross and Blue Shield of Illinois shall, within 5 business days (a) assign an IRO from the list of approved IROs; and (b) notify the Covered Person and the Covered Person's authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Upon assignment of an IRO, Blue Cross and Blue Shield of Illinois or its designated utilization review organization shall, within 5 business days, provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, the Covered Person or the Covered Person's authorized representative may, within 5 business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 5

business days. If Blue Cross and Blue Shield of Illinois or its designated utilization review organization does not provide the documents and information within 5 business days, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by Blue Cross and Blue Shield of Illinois or designated utilization review organization to provide the documents and information to the IRO within 5 business days shall not delay the conduct of the external review. Within 1 business day after making the decision to end the external review, the IRO shall notify Blue Cross and Blue Shield of Illinois, the Covered Person and, if applicable, the Covered Person's authorized representative, of its decision to reverse the determination.

If the Covered Person or the Covered Person's authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to Blue Cross and Blue Shield of Illinois within 1 business day of receipt from the Covered Person or the Covered Person's authorized representative. Upon receipt of such information, Blue Cross and Blue Shield of Illinois may reconsider the Adverse Determination or Final Adverse Determination. Such reconsideration shall not delay the external review. Blue Cross and Blue Shield of Illinois may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within 1 business day after making the decision to end the external review, Blue Cross and Blue Shield of Illinois shall notify the IRO, the Covered Person, and if applicable, the Covered Person's authorized representative of its decision to reverse the determination.

IRO's Decision. In addition, to the documents and information provided by Blue Cross and Blue Shield of Illinois and the Covered Person, or if applicable, the Covered Person's authorized representative, the IRO shall also consider the following information if available and appropriate:

- the Covered Person's medical records;
- the Covered Person's health care Provider's recommendation;
- Consulting reports from appropriate health care Providers and associated records from health care Providers;
- The terms of coverage under the Benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield of Illinois or its designated utilization review organization.

The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above, for a denial of coverage based on a determination that the health care service or treatment recommended or requested is Experimental or Investigational, whether and to what extent (a) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, (b) medical or scientific evidence or evidence-based standards demonstrate that the expected Benefits of the recommended or requested health care service or treatment would be substantially increased over those of available standard health care services or treatments, or (c) the terms of coverage under the Covered Person's Benefit program to ensure that the health care services or treatment would otherwise be covered under the terms of coverage of the Covered Person's Benefit program.

Within 5 days after the date of receipt of the necessary information, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The IRO is not bound by any Claim determinations reached prior to the submission of information to the IRO. The Covered Person and the Covered Person's authorized representative, if applicable, will receive written notice from Blue Cross and Blue Shield of Illinois. The written notice will include:

- A general description of the reason for the request for external review;
- The date the IRO received the assignment from Blue Cross and Blue Shield of Illinois;
- The time period during which the external review was conducted;
- References to the evidence or documentation including the evidence-based standards, considered in reaching its decision;
- The date of its decisions; and
- The principal reason or reasons for its decision, including, what applicable, if any, evidence-based standards that were a basis for its decisions.

If the external review was a review of Experimental or Investigational treatments, the notice shall include the following additional information:

- A description of the Covered Person's medical condition;

- A description of the indicators relevant to whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatments would not be substantially increased over those of available standard health care services or treatments;
- A description and analysis of any medical or scientific evidence considered in reaching the opinion;
- A description and analysis of any evidence-based standards;
- Whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration;
- Whether medical or scientific evidence or evidence-based standards demonstrate that the expected Benefits of the recommended or requested health care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
- The written opinion of the clinical reviewer, including the reviewer's recommendations or requested health care service or treatment that should be covered and the rationale for the reviewer's recommendation.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield of Illinois shall immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review.

Expedited External Review

If the Covered Person have a medical condition where the timeframe for completion of an expedited internal review of a grievance involving an Adverse Determination; (b) a Final Adverse Determination as set forth in the Illinois Managed Care Reform and Patient Rights Act; or, (c) a standard external review as set forth in the Illinois Health Care External Review Act, would seriously jeopardize the Covered Person's life or health or the Covered Person's ability to regain maximum function, then the Covered Person has the right to have the Adverse Determination or Final Adverse Determination reviewed by an IRO not associated with Blue Cross and Blue Shield of Illinois. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which the Covered Person received Emergency Services, but have not been discharged from a facility, then the Covered Person may request an expedited external review.

The Covered Person may also request an expedited external review if the treatment or service in question has been denied on the basis that it is considered Experimental or Investigational and the Covered Person's health care Provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

The Covered Person's request for an expedited independent external review may be submitted orally or in writing.

Notification. Blue Cross and Blue Shield of Illinois shall immediately notify the Covered Person and the Covered Person's authorized representative, if applicable, in writing whether the expedited request is complete and eligible for an expedited external review. Blue Cross and Blue Shield of Illinois's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the IDOI's decision shall be in accordance with the terms of the Benefit program and shall be subject to all Applicable Laws or regulatory guidance, as appropriate.

Assignment of IRO. If the Covered Person's request is eligible for expedited external review, Blue Cross and Blue Shield of Illinois shall immediately assign an IRO from the list of approved IROs; and notify the Covered Person and the Covered Person's authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Upon assignment of an IRO, Blue Cross and Blue Shield of Illinois or its designated utilization review organization shall, within 24 hours provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, the Covered Person or the Covered Person's authorized representative may submit additional information in writing to the assigned IRO. If Blue Cross and Blue Shield of Illinois or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within 1 business day after making the decision to end the external review, the IRO shall notify Blue Cross and Blue Shield of Illinois, the Covered Person and, if applicable, the Covered Person's authorized representative, of its decision to reverse the determination.

Within 2 business days after the date of receipt of all necessary information, the expedited independent external reviewer will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and the Covered Person will receive notification from Blue Cross and Blue Shield of Illinois.

The assigned IRO is not bound by any decisions or conclusions reached during Blue Cross and Blue Shield of Illinois's utilization review process or Blue Cross and Blue Shield of Illinois's internal grievance process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield of Illinois shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the Benefit program if the IRO determines that the health care services being appealed were medically appropriate.

Within 48 hours after the date of providing the notice, the assigned IRO shall provide written confirmation of the decision to the Covered Person, Blue Cross and Blue Shield of Illinois and, if applicable, the Covered Person's authorized representative, including all the information outlined under the standard process above.

An external review decision is binding on Blue Cross and Blue Shield of Illinois. An external review decision is binding on the Covered Person, except to the extent the Covered Person has other remedies available under applicable federal or state law. The Covered Person and the Covered Person's authorized representative may not file a subsequent request for external review involving the same Adverse Determination or Final Adverse Determination for which the Covered Person has already received an external review decision.

BlueCard:

Out-of-Area Services

Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, herein called "the Plan" has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the BlueCross and Blue Shield Association. Whenever a Covered Person accesses healthcare services outside of the Plan's service area, the Claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program and may include negotiated arrangements available between the Plan and other Blue Cross and Blue Shield of Illinois Licensees.

Typically, when accessing care outside Our service area, a Covered Person will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. We explain how we pay both types of Providers below.

BlueCard® Program

Under the BlueCard® Program, when a Covered Person receives Covered Services within the geographic area served by a Host Blue, We will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

For Inpatient facility services received in a Hospital, the Host Blue's Participating Provider is required to obtain Preauthorization. If Preauthorization is not obtained, the Participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction.

Whenever a Covered Person receives Covered Services outside the Plan's service area and the Claim is processed through the BlueCard Program, the amount he/she pays for Covered Services is calculated based on the lower of:

- The billed Covered Charges for a Covered Person's Covered Services, or
- The negotiated price that the Host Blue makes available to the Plan.

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

Suppose a Covered Person receives Covered Services for an illness while he/she is on vacation outside of Illinois. A Covered Person shows their Identification Card to the Provider to let him or her know that he/she is covered by the Plan.

- 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.
- The Host Blue, in turn, forwards the Claim to the Plan and indicates that the negotiated price for the Covered Service is $80. The Plan would then base the amount a Covered Person must pay for the service -- the amount applied to his/her Deductible, if any, and his/her Coinsurance percentage -- on the $80 negotiated price, not the $100 billed charge.

- So, for example, if a Covered Person's Coinsurance is 20%, he/she would pay$16 (20% of $80), not $20 (20% of $100). A Covered Person is 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 a Covered Person has met his/her Deductible and that there are no Copayments associated with the service rendered. A Covered Person's Deductible(s), Coinsurance and Copayment(s) are specified in this Policy.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to a Covered Person's Provider. Sometimes, it is an estimated price that takes into account special arrangements with a Covered Person's 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 Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims as noted above. However, such adjustments will not affect the price We use for a Covered Person's Claim because they will not be applied after a Claim has already paid.

Negotiated (non-BlueCard Program) Arrangements

As an alternative to the BlueCard Program, your Claims for Covered Services may be processed through a Negotiated Arrangement for National Accounts with a Host Blue.

The amount you pay for Covered Services under this arrangement will be calculated based on lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to the Plan by the Host Blue.

Non-Participating Providers Outside the Plan's Service Area

Liability Calculation

When Covered Services are provided outside of the Plan's service area by Non-Participating Providers, the amount a Covered Person pays for such services will be calculated using the methodology described in the Policy for Non-Participating Providers located inside Our service area. A Covered Person may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

Exceptions

In some exception cases, the Plan 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 Plan may make a payment based on the lesser of: The amount calculated using the methodology described in the Policy for Out-of-Network Providers located inside our service area (and described in Section C(1) above); or The following: For Professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have 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 Blue Cross and Blue Shield of Illinois will make for the Covered Services as set forth in this paragraph.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Plan through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If the Plan has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs on your behalf, the Plan will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted for the BlueCard Program.

Inter-Plan Programs: Federal/State Taxes/Surcharge/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Plan will include any such surcharge, tax, or other fee as part of the Claim Charge passed on to you.

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 off"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of Inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a Doctor or Hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. 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 Blue Cross Blue Shield Global Core Service Center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the Hospital will submit your Claims to the Blue Cross Blue Shield Global Core Service Center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. **You must contact the Plan to obtain Preauthorization for non-emergency Inpatient Services.**

Outpatient Services

Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

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

Assignment: Once Covered Expenses are incurred; the Covered Person has no right to request Us not to pay the Claim submitted by the Provider and no such request will be given effect. In addition, we will have no liability to the Covered Person or any other person because of Our rejection of such request.

Unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by BCBSIL sufficiently in advance of BCBSIL's Benefit payment, the Covered Person's Claim for Benefits under this Policy is expressly non-assignable and non-transferable to any person or entity, including any Provider, at any time before or after Covered Expenses are incurred by the Covered Person. Except for the assignment of Benefit payment described above, coverage under this Policy is expressly non-assignable and non- transferable and will be forfeited if the Covered Person attempts to assign or transfer coverage or aid to 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. BCBSIL reserves the right to require submission of a copy of the Assignment of Benefit Payment.

The Covered Person retains the right to revoke, designate or change on a prospective basis only, such Assignment of Benefit Payments, as long as notice of such revocation, designation or change is received by BCBSIL sufficiently in advance of BCBSIL'S Benefit payment. Such revocation, designation or change does not require the consent of the Provider.

Physical Examination and Autopsy: We, at Our own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Reimbursement: If an Insured or an Insured's covered Dependent incurs expenses for Sickness or Injury that occurred due to the negligence of a third-party and Benefits are provided for Covered Services described in the Policy, the Insured shall agree:

- We have the right to reimbursement for all Benefits We provided from any and all damages collected from the third-party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents if the Covered Person is a minor, or the Covered Person's legal representative as a result of that Sickness or Injury, in the amount of the total Allowable Amount or Provider's Claim Charge for Covered Expenses for which We have provided Benefits to the Covered Person, reduced by any Average Discount Percentage ("ADP") applicable to the Covered Person's Claim or Claims.
- We are assigned the right to recover from the third-party, or his or her insurer, to the extent of the Benefits the Plan provided for that Sickness or Injury.

We shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents if the Covered Person is a minor, or the Covered Person's legal representative is or was able to obtain for the same expenses for which We have provided Benefits as a result of that Sickness or Injury.

The Covered Person is required to furnish any information or assistance or provide any documents that Blue Cross and Blue Shield of Illinois may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

Administrative Provisions

Premiums

The premiums for this Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

Changes In Premium Rates

We may change the premium rates with at least 60 days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until 12 consecutive months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, We reserve the right to change rates at any time if any of the following events take place:

- the terms of the Policy change;
- a division, subsidiary, affiliated organization, or eligible class is added or deleted from the Policy; or
- there is a change in the factors bearing on the risk assumed.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Payment of Premium

The first Premium is due on the Policy Effective Date.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period

A grace period of thirty-one (31) days will be allowed for payment of any premium after the first payment. During such grace period the Policy will continue in force provided that the Covered Person has not, prior to the premium due date, given adequate timely written notice to Us that the Policy is to be terminated as of such premium due date.

In addition, if the Covered Person is in default of the Covered Person's obligation to make any premium payment as provided hereunder or if any other default hereunder has occurred and is continuing, then any indebtedness from Us to the Covered Person (including any and all contractual obligations of Us to the Covered Person) may be offset and/or recouped and applied toward the payment of the Covered Person's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due the Covered Person.

If the Covered Person does not pay the premium during the grace period, the Policy will be terminated, at Our option, on the last day of the grace period and the Covered Person will be liable to Us for the payment of all premiums then due, including those for the grace period.

Reinstatement

If this Policy terminates due to default in premium payment(s), the subsequent acceptance of such defaulted premium by Us or any duly authorized agents shall fully reinstate the Policy. For purposes of this section mere receipt and/or negotiation of a late premium payment does not constitute acceptance. Any reinstatement of the Policy shall not be deemed a waiver of either the requirement of timely premium payment or the right of termination for default in premium payment in the event of any future failure to make timely premium payments.

Currency

All premiums for and Claims payable pursuant to the Policy are payable only in the currency of the United States of America.

Par Plan Provider Arrangement

A Provider who is not an In-Network Provider will be considered an Out-of-Network Provider. An Out-of-Network Provider may participate in a Par Plan Arrangement, which is a simple direct-payment arrangement in which the Provider agrees to:

- file all Claims for the Covered Person;
- accept the Allowable Amount determination as payment for Medically Necessary services, and

- not bill the Covered Person for services over the Allowable Amount determination.

Benefits will be subject to the Out-of-Network:

- Deductible, Copayment(s), Coinsurance;
- limitations and exclusions; and
- maximums.

Entire Contract; Changes: This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

All statements made by the Policyholder and Covered Persons shall, in the absence of fraud, be deemed representations and not warranties, and no such statements shall be used in defense to a Claim under the Policy, unless it is contained in a written application. No change in the Policy shall be valid until approved by an executive officer of Us and unless such approval is endorsed hereon or attached hereto. The issuance of this Policy supersedes all previous contracts or policies between the Policyholder and Us which are in force on the Effective Date of Policy.

No agent has the authority to modify or waive any part of the Policy, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer's officers and delivered to the Policyholder.

Overpayment: If Blue Cross and Blue Shield of Illinois 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 was made in error ("Overpayment"), Blue Cross and Blue Shield of Illinois has the right to obtain a refund of the Overpayment from (i) the person to, or for whom, such Benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities or organizations, including, but not limited to, In-Network Providers or Out-of-Network Providers.

If no refund is received, Blue Cross and Blue Shield of Illinois (in its capacity as Insurer or administrator) has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment from:

(a) Any future Benefit payment owed to any person or entity under this Policy, whether for the same or a different Member; or,

(b) Any future Benefit payment owed to any person or entity under another Blue Cross and Blue Shield of Illinois - administered ASO Benefit program and/or Blue Cross and Blue Shield of Illinois administered insured Benefit program or policy; or,

(c) Any future Benefit payment owed to any person or entity under another Blue Cross and Blue Shield of Illinois insured group Benefit plan or individual policy; or,

(d) Any future Benefit payment, or other payment, made to any person or entity; or,

(e) Any future payment owed to one or more In-Network Providers or Out-of-Network Providers.

Further, Blue Cross and Blue Shield of Illinois has the right to reduce your Policy's payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield plan or Policy Overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield of Illinois plan or policy.

Policy Effective Date: The Policy begins on the Policy Effective Date at 12:01 AM, Standard Time at the address of the Policyholder.

Policy Termination: We may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Policyholder, or such other notice, if any, permitted by Applicable Law or regulatory guidance. Either We or the Policyholder may terminate this Policy on any Premium due date by giving 31 days advance written (authorized electronic or telephonic) notice to the other, or such other notice, if any, permitted by Applicable Law or regulatory guidance. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Policyholder and Us.

This Policy terminates automatically on the earlier of:

- the Policy Termination Date shown in the Policy; or
- the Premium due date if Premiums are not paid when due.

Termination takes effect at 12:00 AM, Standard Time at the address of the Policyholder on the date of termination.

Premium Rebates, and Premium Abatements; and Cost-Sharing:

- Rebate. In the event federal or state law requires Blue Cross and Blue Shield of Illinois to rebate a portion of annual premiums paid, Blue Cross and Blue Shield of Illinois will provide any rebate as required or allowed by such federal or state law.

- Abatement. Blue Cross and Blue Shield of Illinois may determine to abate (all or some of) the premium due under this Policy for particular period(s).
- Any abatement of premium by Blue Cross and Blue Shield of Illinois represents a determination by Blue Cross and Blue Shield of Illinois not to collect premium for the applicable period(s) and does not affect a reduction in the rates under this Policy. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future periods.
- Blue Cross and Blue Shield of Illinois makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding, or reporting requirements). It will be the obligation of each person owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state, or local laws or regulations.
- Cost-sharing**.** Blue Cross and Blue Shield of Illinois reserves the right to waive or reduce the Coinsurance, Copayments and/or Deductibles under this Policy.

Examination of Records and Audit: We shall be permitted to examine and audit the Policyholder's books and records at any time during the term of the Policy and within 2 years after final termination of the Policy as they relate to the Premiums or subject matter of this insurance.

Clerical Error: A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Limitations of Actions: No legal action shall be brought to recover under the Policy prior to the expiration of sixty (60) days after a Claim has been furnished to Us in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to Us. No extension of the time granted under the Policy shall in any way extend this ''**Limitation of Actions**'' provision.

Time Limit on Certain Defenses: After 2 years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for this Policy shall be used to void this Policy or to deny a Claim for loss incurred.

Misstatement of Age: In the event the age of a Participant has been misstated, the premium rate for such person shall be determined according to the correct age as provided in this Policy and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate at the true age for the Participant.

Conformity with State Statutes: Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

Illegal Occupation: Any loss to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person's being engaged in an illegal occupation.

Not in Lieu of Workers' Compensation. This Policy is not a Workers' Compensation Policy. It does not provide any Worker's Compensation Benefit.

Information and Medical Records: All Claim information, including, but not limited to, medical records, will be kept confidential and except for reasonable and necessary business use, disclosure of such confidential Claim information would not be performed without the authorization of the Covered Person or as otherwise required or permitted by Applicable Law or regulatory guidance.

Proprietary Materials: The Policyholder acknowledges that We have developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures, and information, all of which are proprietary information ("Business Proprietary Information"). The Policyholder shall not use or disclose to any third- party Business Proprietary Information without Our prior written consent.

Neither party shall use the name, symbols, trademarks or service marks of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that We may include the Policyholder in Our list of clients.

Our Separate Financial Arrangements Regarding Prescription Drugs:

The Policyholder's experience account under the Policy, if any, the maximum amount of Benefits payable by the Plan and all required Copayment, Deductible and Coinsurance amounts under this Policy shall be calculated on the basis of the Allowable Amount or the agreed upon cost between the Participating Prescription Drug Provider as defined below, and Us, whichever is less.

The Plan hereby informs the Policyholder and all Covered Persons that it has arrangements with Prescription Drug Providers (''Participating Prescription Drug Providers") for the provision of, and payment for, Prescription Drug services to all persons entitled to Prescription Drug Benefits under individual certificates, group health insurance policies and contracts to which We are a party, including the Covered Persons under the Policy, and that pursuant to Our contracts with Participating Prescription Drug Providers, under certain circumstances described therein, We may receive discounts for Prescription Drugs dispensed to Covered Persons under the Policy.

The Policyholder understands that We may receive such discounts during the term of the Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such discounts in excess of any amount that may be reflected in the premium specified on a Benefit program and premium notification letter, if any; or applicable rate summary, if any, as part of any experience rating refund, if applicable to this Policy, or otherwise.

Separate Financial Arrangements with Pharmacy Benefit Managers:

We hereby inform the Policyholder and all Covered Persons that it owns a significant portion of the equity of Prime Therapeutics LLC and that We have entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, Prescription Drug Benefits to all persons entitled to Prescription Drug Benefits under individual certificates, group health insurance policies and contracts to which We are a party, including the Covered Persons under the Policy. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. Pharmacy Benefit Managers may share a portion of those rebates with Us. The Policyholder understands that We may receive such rebates during the term of the Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such rebates except to the extent they may be calculated into the premium; a Benefit program and premium notification letter, if any; or applicable rate summary, if any, as part of any experience rating refund, if applicable to this Policy, or otherwise.

Severability: In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions of this Policy and the Policy shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

Third Party Data Release: In the event the Policyholder directs Us to provide data directly to its third-party consultant and/or vendor, and We agree, then the Policyholder acknowledges and agrees, and will cause its third-party consultant and/or vendor to acknowledge and agree:

The personal and confidential nature of the requested documents, records, and other information. Release of the Confidential Information may also reveal Our confidential, business proprietary and trade secret information

To maintain the confidentiality of the Confidential Information and any Proprietary Information The third-party consultant and/or vendor shall:

a. Use the Information only for the purpose of complying with the terms and conditions of its contract with the Policyholder.
b. Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the performance of duties under its contract with the Policyholder.
c. Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.
d. Use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.
e. Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of the Policy or as required by law.

Not to use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use.

The third-party consultant and/or vendor shall execute the Plan's then-current confidentiality agreement.

The Policyholder shall designate the third-party consultant and/or vendor on the appropriate HIPAA documentation.

The Policyholder shall provide Us with the appropriate authorization and specific written directions with respect to data release or exchange with the third-party consultant and/or vendor.

The Policyholder shall indemnify, defend (at Our request) and hold harmless Us and Our employees, officers, directors and agents against any and all losses, liabilities, damages, penalties and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of Claims, lawsuits, demands, settlements or judgments brought against Us in connection with any Claim based upon Our disclosure to the third party consultant and/or vendor of any information and/or documentation regarding any Covered Person at the direction of the Policyholder or breach by the third party consultant and/or vendor of any obligation described in the Policy.

Identity Theft Protection Services: Blue Cross and Blue Shield of Illinois makes available at no additional cost to the Covered Persons identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect the Covered Person's information. These identity theft protection services are currently provided by Blue Cross and Blue Shield of Illinois designated outside vendor and acceptance or declination of these services is optional to the Covered Person. Covered Persons who wish to accept such identity theft protection services will need to individually enroll in the program by calling the toll-free telephone number on the back of their Identification Card or by visiting Our website at www.bcbsil.com. Services may automatically end when the person is no longer an eligible Covered Person. Service may change or be discontinued at any time with or without notice and Blue Cross and BlueShield of Illinois 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 program.

Notice of Annual Meeting: The Policyholder is hereby notified that it is a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative or by proxy at all meetings of Members of said Company. The annual meeting is scheduled to be held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m. For purposes of this paragraph the term "Member" means the group, trust, association, or other entity to which this Policy has been issued. It does not include Covered Persons under the Policy. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in the Policy to "premium(s)" shall mean "charge(s)."

Blue Cross and Blue Shield of Illinois pays indemnification or advances expenses to a director, officer, employee, or agent consistent with Blue Cross and Blue Shield of Illinois's bylaws then in force and as otherwise required by Applicable Law.

Service Mark Regulation: On behalf of the Policyholder and its Covered Persons, the Policyholder hereby expressly acknowledges its understanding that the Policy constitutes a contract solely between the Policyholder and Us. We are an independent corporation operating under a license with the Blue Cross and Blue Shield Association (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits Us to use the Blue Cross and Blue Shield Service Mark in the Our service area and We are not contracting as the agent of the Association. The Policyholder further acknowledges and agrees that it has not entered into the Policy based upon representations by any person other than persons authorized by Us and that no person, entity, or organization other than the Insurer shall be held accountable or liable to the Policyholder for any of the Our obligations to the Policyholder created under the Policy. This paragraph shall not create any additional obligations whatsoever on Our part, other than those created under other provisions of this Policy.

Rescission of Coverage: Any act, practice, or omission that constitutes fraud, or any intentional misrepresentation made by or on behalf of anyone seeking coverage under this Policy, may result in the cancellation of the Covered Person's coverage (and/or the Covered Person's Dependent(s) coverage) retroactive to the Effective Date – (a "Rescission"), subject to 30 days prior notification, or such other notice. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates. Any intentional fraudulent misstatement or omissions, or intentional misrepresentation of a material fact on the Covered Person's application, or any practice that constitutes fraud may result in a Rescission of the Covered Person's coverage (and/or the Covered Person's Dependent(s) coverage) retroactive to the Effective Date, subject to prior notification. The Covered Person has the right to appeal this Rescission and an independent third party may review the decision. In the event of Rescission, Blue Cross and Blue Shield of Illinois may deduct from the premium refund any amounts made in Claim Payments during this period and you may be liable for any Claim Payment amount greater than the total amount of premiums paid during the period for which Rescission is affected.

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.