AcademicBlue℠

Rosalind Franklin University Student Health Insurance Plan 2026-2027

Underwritten by: Blue Cross and Blue Shield of Illinois

Please review to understand your coverage.

Medical Account Number: 125284

9202234.0226

AcademicBlue℠

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

1-800-538-8833

NOTICE OF 10-DAY RIGHT TO EXAMINE POLICY

Within ten days after its delivery to You, this Student Health Policy may be surrendered by returning it to 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 (herein referred to as "Blue Cross and Blue Shield", "BCBSIL", "Insurer", "We", "Us" and "Our") at Our administrative office, agent, or the entity through whom it was purchased. Upon such surrender, any Premiums paid will be returned. The Student is responsible for repaying BCBSIL for any services rendered or Claims paid by BCBSIL on behalf of the Student and/or any Dependents during the ten-day examination period.

POLICYHOLDER:	Rosalind Franklin University
POLICY NUMBER:	125284 ("the Policy")
EFFECTIVE DATE:	June 1, 2026
POLICY TERM:	June 1, 2026 through May 31, 2027
PREMIUM DUE DATE:	On or before the Policy Effective Date

This **policy** describes the terms and conditions of coverage as issued to the policyholder named above. This **policy** is issued in the state of Illinois and is governed by its laws. This **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 and the policyholder have agreed to all of the terms of this **policy** as stated herein.

Policyholder has confirmed to us 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 you have any questions once you have read this **policy**, you can call us at the toll-free telephone number on the back of your **identification card**. It is important to all of us that you understand the protection this coverage gives you.

Signed for 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 by:

Brian Snell
Plan President, Blue Cross and Blue Shield of Illinois

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.

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SCHEDULE OF BENEFITS

Your **benefits** are highlighted below. However, to fully understand your **benefits**, it is very important that you read this entire **policy**. Although you can go to the **hospital** or **provider** of your choice, **benefits** under this **policy** will be greater when you use the services of a network **provider**. Your **deductible** applies to all **benefits** described below, unless otherwise stated.

Deductible:	**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

Out-of-Pocket Maximum:	**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

Prior Authorization Penalty:	**Network Provider**	**Out-of-Network Provider**
Penalty for failure to obtain Prior Authorization for Inpatient admissions or other services needing Prior Authorization as shown in the ***Prior Authorization Requirements*** section of this Policy.	$500	$500

Covered Expenses	**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 Procedures	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 Care/Chemical Dependency	20% of Allowable Amount	40% of Allowable Amount
Substance Use Disorder	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
- Assistant Surgeon Services	20% of Allowable Amount	40% of Allowable Amount
- Anesthetist Services	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
Mental Health Care/Chemical Dependency	20% of Allowable Amount	40% of Allowable Amount
Substance Use Disorder	20% of Allowable Amount	40% of Allowable Amount
Emergency Room **Accidents and Emergency Care (including Accidents, and Emergency Care and Non-Emergency Care for Behavioral Health Services)**		
Facility Charges (excluding certain diagnostic procedures)	20% of Allowable Amount $200 Copayment (Waived if admitted to the Hospital as an Inpatient immediately following emergency treatment) Deductible Waived	
Physician Charges	20% of Allowable Amount	
Diagnostic X-Ray and Laboratory Services	20% of Allowable Amount	
Emergency Room **Non-Emergency Care**		
Facility Charges (excluding certain diagnostic procedures)	20% of Allowable Amount $200 Copayment Deductible Waived	40% of Allowable Amount $200 Copayment
Physician Charges	20% of Allowable Amount	
Diagnostic X-ray and Laboratory Services	20% of Allowable Amount	
Other Expenses		
Ground and Air Ambulance Transportation**	20% of Allowable Amount	
Urgent Care	$30 Copayment Deductible Waived	40% of Allowable Amount
Preventive Care Services	No Charge	40% of Allowable Amount
Routine Well-Baby Care	No Charge	40% of Allowable Amount
Routine Pediatric Hearing Examinations	No Charge	40% of Allowable Amount
Office Visits Including Office Visits for Behavioral Health Services	$30 Copayment Deductible Waived	40% of Allowable Amount
Specialist Office Visits	$60 Copayment Deductible Waived	40% of Allowable Amount
Telehealth Visits Including Telehealth Visits for Behavioral Health Services	$30 Copayment Deductible Waived	40% of Allowable Amount

Specialist Telehealth Visits Including Specialist Telehealth Visits for Behavioral Health Services	$60 Copayment Deductible Waived	40% of Allowable Amount
Radiation and Chemotherapy Services	20% of Allowable Amount	40% of Allowable Amount
Allergy Testing and Allergy Injections (Copayment and/or Coinsurance 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
Additional Surgical Opinion	20% of Allowable Amount	40% of Allowable Amount
Autism Spectrum Disorder Visit limitations are not Applicable to treatment of Autism and Autism Spectrum Disorders	20% of Allowable Amount	40% of Allowable Amount
Durable Medical Equipment	20% of Allowable Amount	40% of Allowable Amount
Orthotic Devices Benefits will be limited to 2 orthotic devices or 1 pair of foot orthotic devices per Benefit Period	20% of Allowable Amount	40% of Allowable Amount
Habilitative Services and Devices	20% of Allowable Amount	40% of Allowable Amount
Dental Treatment (Injury only to sound, natural teeth)	20% of Allowable Amount	
Tests and Procedures	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
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	No Charge	40% of Allowable Amount
Extended Care Expenses		
Skilled Nursing Facility No Benefit Period Visit Maximum	20% of Allowable Amount $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	40% of Allowable Amount
Private Duty Nursing Services No Benefit Period Visit Maximum	20% of Allowable Amount	40% of Allowable Amount
Cardiac Rehabilitation Services	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 permittable by **applicable law.**

* You will be responsible for the difference between the **allowable amount** and the billed charges, when receiving **covered services** from an **out-of-network provider**. For questions concerning **out-of-network providers**, please call Blue Cross and Blue Shield of Illinois Customer Service at the toll-free telephone number on the back of your **identification card**.

** 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

Certain covered drugs may be available at no cost through a **participating pharmacy** for the following categories of medication:

- Severe allergic reactions
- Hypoglycemia
- Opioid overdoses
- Nitrates

For further information, call the toll-free telephone number on the back of your **identification card**.

Pharmacy Deductible

Separate Pharmacy Deductible	
Per Covered Person per Benefit Period:	$150

Retail Pharmacy Benefit

Retail Pharmacy:	**Participating Pharmacies Covered Person Pays**	**Non-Participating Pharmacies Covered Person Pays****
Preferred Generic Drugs; and Preferred Generic diabetic supplies, insulin, and insulin syringes	$15 Copayment	50% of Allowable Amount After $15 Copayment
Non-Preferred Generic Drugs; and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	$15 Copayment	50% of Allowable Amount After $15 Copayment
Preferred Brand Name Drugs; and Preferred Brand Name diabetic supplies, insulin, and insulin syringes The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $35 when obtained from a Participating Pharmacy.	$40 Copayment	50% of Allowable Amount After $40 Copayment
Non-Preferred Brand Name Drugs; and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $35 when obtained from a Participating Pharmacy.	$100 Copayment	50% of Allowable Amount After $100 Copayment
Preferred Specialty Drugs	N/A	N/A
Non-Preferred Specialty Drugs	N/A	N/A

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

You can purchase a 90-day supply for 3 times the schedule amount listed above.

** **Non-participating pharmacies**: When you obtain **prescription drugs**, including diabetic supplies from a **non-participating pharmacy**, **benefits** will be provided at 50% of the amount you would have received had you obtained drugs from a network **pharmacy** minus the **copayment** amount or **coinsurance** amount.

Specialty Pharmacy Benefit

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

Specialty Pharmacy Benefit*:	**Specialty Pharmacy Covered Person Pays**
Preferred Generic Drugs; and Preferred Generic diabetic supplies, insulin, and insulin syringes	N/A
Non-Preferred Generic Drugs; and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	N/A
Preferred Brand Name Drugs; and Preferred Brand Name diabetic supplies, insulin, and insulin syringes The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $35 when obtained from a Participating Pharmacy.	N/A
Non-Preferred Brand Name Drugs; and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $35 when obtained from a Participating Pharmacy.	N/A
Preferred Specialty Drugs	$125 Copayment
Non-Preferred Specialty Drugs	$125 Copayment

SCHEDULE OF BENEFITS FOR PEDIATRIC VISION CARE SERVICES

Only for Covered Persons under the age of 19

Vision Care Services	EyeMed Provider Benefit	Non-Contracting Provider Reimbursement Amount
Exam (with dilation as necessary):	No Copayment	Up to $30
Frames:		
Any available frame at provider location	No Copayment on provider-designated frame $150 allowance on non-provider designated frame 20% off balance over $150	Up to $75
Standard Plastic 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
Lens Options:		
UV Treatment	No Copayment	Up to $12
Tint (Fashion & Gradient & Glass-Grey)	No Copayment	Up to $12
Standard Plastic Scratch Coating	No Copayment	Up to $12
Standard Polycarbonate	No Copayment	Up to $32
Glass	No Copayment	Up to $12
Oversized	No Copayment	N/A
Photochromic / Transitions Plastic	No Copayment	Up to $57
Contact Lenses: (Contact Lens allowance includes materials only)		
Conventional	1 pair from selection of provider designated contact lenses	Up to $150
Disposable	Up to 3 month supply of daily disposable, single vision spherical contact lenses	Up to $150

Medically Necessary 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).	No Copayment, Paid-in-Full	Up to $210

Frequency:

Examinations, Lenses, or Contact Lenses	Once every benefit period
Frames	Once every benefit period

Routine eye exams do not include professional services for contact lens evaluations. Any Applicable fees are the responsibility of the patient.

Value-added features:

Laser vision correction: 15% off Retail Price or 5% off promotional price.

Additional Pairs Benefit: Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded Benefit has been used.

Additional Benefits

Medically Necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be 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 dispensed in lieu of other eyewear. Participating Providers will obtain the necessary Prior Authorization for these services.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for Our Covered Persons with low vision. Covered low vision services (both Contracting and Non-Contracting) will include one comprehensive low vision evaluation every 5 years; items such as high-power spectacles, magnifiers, and telescopes; and follow-up care – four visits in any five-year period. Participating Providers will obtain the necessary Prior Authorization for these services.

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.

Note: Additional discounts on materials may be available.

*The covered charge is the rate negotiated with network **providers** for a particular **covered service**.

**The plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.

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 you receive from those providers.

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

YOU CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THIS **POLICY** IN NON-EMERGENCY SITUATIONS. Except in limited situations governed by the federal No Suprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), Non-participating **providers** furnishing non-emergency services may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. If you elect to use a non-participating **provider**, plan **benefit** payments will be determined according to your **policy's** fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by this **policy**. Participating **providers** have agreed to ONLY bill members the cost-sharing amounts. You 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 your **identification card**.

If you have made a good faith effort to utilize participating **providers** for a covered service and it is determined that we do not have the appropriate participating **providers** due to insufficient number, type, unreasonable travel distance or delay, or the participating **provider** refusing to provide a covered service because it is contrary to the conscience of the participating **providers**, as protected by the Health Care Right of Conscience Act, we shall give you a network exception and ensure that you will be provided the covered service at no greater cost than if the service had been provided by a participating **provider**. This does not apply if you willfully choose to access a non-participating **provider** for services available to the panel of participating **providers**.

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ELIGIBILITY FOR INSURANCE

Each person in one of the classes of eligible persons shown below is eligible to be insured under this **policy**. This includes anyone who is eligible on the **policy** effective date and may become eligible after the **policy** effective date while this **policy** is in force. **Students** must meet the **institution's** requirements for maintaining their status as an eligible **student**. Some courses may not fulfill the eligibility requirements. Please contact your **institution** for further information. **Students** must maintain their eligibility in order to maintain or continue coverage under this **policy**. **Students** enrolled for the summer sessions will not experience a loss in coverage as long as they were covered immediately preceding summer sessions. (These **students** may be eligible for continuation coverage as provided for in this **policy**.) We maintain the right to investigate **student** status and attendance records to verify that eligibility requirements have been met.

Classes Of Eligible Persons

Class 1: **All enrolled Students are eligible for coverage under this policy**.

Dependents are eligible for coverage without **student** enrollment.

Class 2: **Domestic Students**

All Undergraduate and Graduate **students** taking 12 or more credit hours are required to enroll in this **policy** unless proof of comparable coverage is provided.

Class 3: **International Students**

All International **students** are required to enroll in this **policy** unless proof of comparable coverage is provided.

NOTE: Multiple classes may be added depending on the **institution**.

You may be insured only under one class of eligible persons even though you may be eligible under more than one class.

Dependents, as defined by this **policy**, of all **students** are eligible for coverage under this **policy**.

You may not be insured as a **dependent** and a **student** at the same time.

Your **dependent** is eligible on the date:

- You are eligible if you have **dependents** on that date
- The date the person becomes your **dependent**, if later

Individuals who are eligible to receive Medicare benefits are not eligible to enroll in this plan unless they fall within a federal exception.

No eligibility rules or variations in premium will be imposed based on a student's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, quality of life, or any other health status factor. A student will not be discriminated against for coverage under this policy on the basis of race, color, national origin, disability, age, expected length of life, sex, gender identity, sexual orientation, or political affiliation. Coverage does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving benefits. Variations in the administration, processes or benefits of this policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

IMPORTANT INFORMATION

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 the toll-free telephone number on the back of your **identification card**.

Accident And Sickness Medical Expense Benefits

Unless otherwise specified, any **deductibles**, **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 you have **family coverage**, each member of your family must satisfy the **deductible**. If your family has satisfied the family **deductible** amount shown on your **SCHEDULE OF BENEFITS** for **covered expenses** rendered by **in-network provider(s)** and a separate family **deductible** amount shown on your **SCHEDULE OF BENEFITS** for **covered expenses** rendered by **out-of-network provider(s)** or **non-plan provider(s)**, it will not be necessary for anyone else in your 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 your family ever receive **covered services** as a result of **injuries** received in the same **accident**, only one **deductible** will be applied against those **covered services**.

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
- The payments for which you are 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 your 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 your 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 **prior authorization** 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**
- **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**
- The payments for **covered services** rendered by an **out-of-network provider** for which you are 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 your out-of-network **out-of-pocket maximum** is reached:

- Charges that exceed the **allowable amount**
- The **coinsurance** resulting from **covered services** you may receive from an **in-network provider**
- The **coinsurance** resulting from **covered services** you may receive from an out-of-network **hospital**
- Penalty amounts for failing to follow **prior authorization** requirements
- Services, supplies, or charges limited or excluded in this **policy**
- Expenses not covered because a **benefit** maximum has been reached
- Any **covered expenses** paid by the primary plan when BCBSIL is the secondary plan for purposes of coordination of **benefits**

If you have **family coverage**, each member of your family must satisfy the **out-of-pocket maximum**. If your family has satisfied the family **out-of-pocket maximum** shown on your **SCHEDULE OF BENEFITS** for **covered expenses** rendered by **in-network provider(s)** and a separate amount shown on your **SCHEDULE OF BENEFITS** family **out-of-pocket maximum** for **covered expenses** rendered by **out-of-network provider(s)**, it will not be necessary for anyone else in your 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.

UTILIZATION MANAGEMENT

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** in the **GLOSSARY** section 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 **GENERAL PROVISIONS** 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 BlueCard® Program in the **CLAIM PROVISIONS** 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 the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com/find-care/utilization-management 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 you 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**.

NOTE: Prior Authorization is not required for Behavioral Health Inpatient Admissions at Participating Hospitals. The first 72 hours of such coverage will not be subject to concurrent review if the Participating Hospital notifies BCBSIL of the admission and the initial treatment plan within 48 hours of admission. Please see the **Contacting Behavioral Health** section below for more information regarding other Behavioral Health Prior Authorizations or Recommended Clinical Review requests.

Prior authorization not required for maternity care and treatment of breast cancer unless extension of minimum length of stay requested.

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

- Maternity care:
  - 48 hours following an uncomplicated vaginal delivery
  - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of breast cancer:
  - 48 hours following a mastectomy
  - 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 the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com/find-care/utilization-management 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

A 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 of 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/utilization-management 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, 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 you may become ineligible as of the date of service or your **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 your 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, prescriptions, 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**.

NOTE: If your **provider** determines you are experiencing a high-risk pregnancy, you will have access to clinically appropriate case management programs.

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 **Exclusions And Limitations** section of this **policy**.

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.

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** disagree with the determination you have the right to appeal the decision. Please refer to the **Claim Appeal Procedures** provision in the **Claim Provisions** section of this **policy** 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 663099
Dallas, TX 75266-3099

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:

- BCBSIL will review the **medical necessity** of your treatment or service prior to the final **benefit** determination.
- If BCBSIL determines the treatment or service is not **medically necessary** or is experimental and/or investigational, **benefits** will be reduced or denied.

GLOSSARY

Throughout this **policy**, many words are used which have a specific meaning when applied to your health care coverage. These terms will always be bolded. When you come across these terms while reading this **policy**, you can refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your **benefits**. If a term within a definition is bolded, 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 "BCBSIL", "Blue Cross and Blue Shield of Illinois", "Blue Cross and Blue Shield", and "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 the **ELIGIBILITY FOR INSURANCE** section of this **policy** for eligibility information.

Accident means an **accident** that results in accidental bodily damage, harm or **injury** occurring while you are insured under this **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 you 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 you 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
- 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 your home, scene of **accident** or medical emergency to a **hospital**, between **hospital** and **hospital**, between **hospital** and skilled nursing facility or from a skilled nursing facility or **hospital** to your home. If there are no facilities in the local area equipped to provide the care needed, **ambulance transportation** then means the transportation to the closest facility that can provide the necessary service. **Ambulance transportation** provided for the convenience of you, your family/caregivers, **physician**, or the transferring facility, is not considered **medically necessary** and is not covered under this **policy**.

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

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.

Approval by a governmental or regulatory agency will be taken into consideration in assessing **experimental/investigational** status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative. **Prescription drugs** that are approved by the FDA through the accelerated approval program may be considered **experimental/investigational**.

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
- 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 you by **hospitals** and certain other health care facilities for purposes of calculating **deductibles**, **coinsurance** amounts, **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 your **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 you 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 us and the **policyholder**.

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, partial or whole genome sequencing, and **medically necessary** home saliva cancer screenings once every twenty-four (24) months if you are at high risk or showing symptoms of the disease being tested for.

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

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 you, 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 you, 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 you are 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 you must pay before **benefits** are payable under this **policy**.

Covered Accident means an **accident** that occurs while coverage is in force for you and results in a loss or **injury** covered by this **policy** for which **benefits** are payable.

Covered Expenses means expenses actually incurred by or on behalf of you for treatment, services and supplies not excluded or limited by this **policy**. Coverage under this **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, which 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 your condition. **Custodial care services** also means those services which do not require the technical skills, professional training, and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

Deductible means the 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 this **policy**.

Dependent means:

- Your lawful spouse including **domestic partner**
- Your partner in a **civil union** (unless indicated otherwise, the term spouse includes a partner in a **civil union**)
- Your child(ren)

"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 your **domestic partner**, a child(ren) who is in your 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 your child(ren), grandchild(ren), child(ren) for whom you are 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:

- Live within the service area of Blue Cross and Blue Shield of Illinois network for this **policy**
- Have served as an active or reserve member of any branch of the Armed Forces of the United States
- 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 you 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 your symptoms and which are directed toward evaluation or progress of a condition, disease, or **injury**. Such tests include, but are not limited to, x-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 their services are rendered and acting within the scope of that license or certificate. It will not include you or a member of your **immediate family** or household.

Domestic Partner means a person with whom you have entered into a **domestic partnership**.

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

- You and your **domestic partner** have lived together for at least 6 months
- Neither you nor your **domestic partner** is married to anyone else or has another **domestic partner**
- Your **domestic partner** is at least 18 years of age and mentally competent to consent to contract
- Your **domestic partner** resides with them and intends to do so indefinitely
- You and your **domestic partner** have an exclusive mutual commitment similar to marriage
- You and your **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 the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com. You may also call Customer Service at the 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, an **autism spectrum disorder,** and cerebral palsy.

Eligible Charge means 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 this **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**.

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 this **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**):
   - The **provider's** billed charges
   - 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**

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**):
   - The **provider's** billed charges
   - 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

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
- With respect to a pregnant woman who is having contractions:
  - Inadequate time to complete a safe transfer to another **hospital** before delivery
  - 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 (including emerging technologies, services, procedures, and service paradigms) 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.

Family Coverage means coverage for you and your 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. You 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 you keep, learn, or improve skills and functioning for daily living, as prescribed by your **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.

Hippotherapy means the use of equine movement by a licensed occupational therapist, a licensed physical therapist, or a speech language pathologist, in conjunction with a professional horse handler and a therapy horse, to engage sensory, neuromotor, and cognitive systems to promote functional outcomes.

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
- Provides 24-hour nursing services by or under the supervision of a registered nurse
- 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 you are admitted to and discharged from a **hospital** within a 24-hour period but are confined as a bed-patient during the duration in the **hospital**, the admission shall be considered a **hospital confinement**.

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

Identification Card means the card issued to you by Blue Cross and Blue Shield of Illinois providing pertinent information applicable to your coverage.

Immediate Family means your 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 you at the time services are rendered to you and has been designated by us as an **in-network provider**.

Injury means accidental bodily **injuries** sustained by you 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 you are 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 this **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 you when you have lost some capacity for self-care because of a chronic illness, **injury**, or condition.

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 you 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 you. When applied to **hospital inpatient** services, **medically necessary** means that your medical symptoms or condition require that the treatment be provided to you as an **inpatient** and that treatment cannot be safely provided to you as an **outpatient**. Further, **medically necessary** means that **inpatient hospital** care and treatment will not be covered when your medical symptoms and condition no longer necessitate your 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 **prior authorization**, 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.

Naprapathy means the identification, evaluation, and treatment of those with connective tissue disorders by the use of connective tissue manipulation, therapeutic and rehabilitative exercise, postural counseling, and the use of the effective properties of physical measures and assistive devices for the purpose of preventing, correcting, or alleviating a physical disability.

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, **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 Blue Cross and Blue Shield of Illinois 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**, which 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.

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

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 you 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 Customer Service at the toll-free telephone number on the back of your **identification card**.

Out-of-Pocket Maximum means the maximum liability that may be incurred by you in a **benefit period** before **benefits** are payable at 100% of the **allowable amount**.

Outpatient means that you are receiving treatment while not an **inpatient**. Services considered **outpatient** include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an **inpatient** in a health care facility.

Partial Hospitalization Treatment Program means a Blue Cross and Blue Shield approved planned program of a **hospital** or **substance use disorder treatment facility** for the treatment of **mental illness** or **substance use disorder treatment** in which patients spend days. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an **inpatient unit**, i.e., medically supervised by a **physician** and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available in person, or by telephone, to provide assistance and direction to the program as needed. Participants at this level of care do not require 24-hour supervision and are not considered a resident at the program. Requirements: Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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.

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

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 they practice.

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, your application(s) for coverage, as appropriate, along with any exhibits, appendices, addenda and/or other required information.

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:

- Prescription legend drugs
- Compound medications of which at least one ingredient is a prescription legend drug
- **Prescription drugs** that have been approved by the FDA for one protocol will be covered when found to be effective and prescribed for another
- 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 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**.

Prior Authorization means a requirement that you must obtain authorization from BCBSIL before you receive certain types of **covered services** designated by Blue Cross and Blue Shield of Illinois.

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**, pharmacist, 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 you at the time services are rendered to you.
- **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.

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
- 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

Rehabilitative Services means including, but not limited to, **speech therapy**, **physical therapy** and **occupational therapy**. Treatment as determined by your **physician**, who must be either:

- 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
- 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.

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
- 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
- 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 yours that causes a loss for which you incur medical expenses while covered under this **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**, you should refer to the **drug list** by calling the toll-free telephone number on the back of your **identification card** or visiting the Blue Cross and Blue Shield of Illinois 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.

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
- The **physician** or professional other **provider** has had the appropriate training and experience to provide the treatment or procedure

Student means an individual **student** who meets the eligibility requirements for this health coverage, as described in the eligibility requirements of this **policy**. See the **ELIGIBILITY FOR INSURANCE** section of this **policy** 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**, **copayments**, **coinsurance**, or other cost sharing for purposes of the preventive care services **benefits**, 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 their 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
- With the presence of signs or symptoms compatible with acute infection of borrelia or other **tick-borne diseases**

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

EFFECTIVE DATE OF COVERAGE

Insurance for an eligible **student** who enrolls during the program's enrollment period, as established by the **institution**, is effective on the latest of the following dates:

- The **policy** effective date
- The date we receive the completed online enrollment form
- The date after the required premium is paid
- The date you enter the eligible class

If coverage for **dependents** is offered, coverage for your eligible **dependent** who enrolls: (1) during the enrollment period established by the policyholder; (2) within 31 days after you acquire a new **dependent**; or (3) within 31 days after a **dependent** terminates coverage under another health care plan; is effective on the latest of the following dates:

- The first day of the **policy** term coverage period
- The date you enter the eligible class
- The date we receive the completed enrollment form
- The date after the required premium is paid

After the time periods described above, you or your **dependent** must wait until the next enrollment period, except for a newborn or a newly adopted child or if there is an involuntary loss of coverage under another health care plan.

We will pay **benefits** for a newborn child of a **covered person** from the moment of birth until that child is 31 days old. Coverage may be continued beyond the 31 days if you notify us of the child's birth and pay the required premium, if any.

Adopted children, as defined by this **policy**, will be covered on the same basis as a newborn child from the date the child is placed for adoption with the insured or the date the insured becomes a party to a suit for the adoption of the child. Coverage will cease on the date the child is removed from placement and the insured's legal obligation terminates.

Coverage for newborn and adopted children will consist of coverage for covered **injury** or covered **sickness** including the necessary care and treatment of medically diagnosed congenital defects, prematurity, well baby care, birth abnormalities, and routine nursery care related with a covered sickness.

Open Enrollment Periods

The **institution** will designate open enrollment periods, during which you may apply for or change coverage for themself and/or their eligible spouse and/or **dependents**.

This **Open Enrollment Periods** section is subject to change by BCBSIL, and/or **applicable law** or regulatory guidance, as appropriate.

Qualifying Event

You or your **dependents** who have a change in status and lose coverage under another health care plan are eligible to enroll for coverage under this **policy**. Within 31 days of the qualifying event, you and/or your **dependents** must complete supporting documentation. Go to www.bcbsil.com, click on "Shop for Student Health Plans" and select your **institution** for more information. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce, annulment, or legal separation, gain of a dependent whether by birth, adoption, or placement for adoption or court-ordered **dependent** coverage, loss of dependent status because of age, or you become pregnant, as certified by a qualified **provider**, including a professional midwife (you must request coverage within 60 days of such eligibility). The premium will either be the same as or prorated based on what it would have been at the beginning of the semester or quarter, whichever applies. However, the effective

date will be the later of the date you enroll for coverage under this **policy** and pay the required premium, or the day after the prior coverage ends. Please contact your **institution** for further information.

DISCONTINUANCE OF INSURANCE

Termination Date Of Insurance

Your coverage will end on the earliest of the date:

- This policy terminates
- You are no longer eligible
- The period ends for which premium is paid

If coverage is offered for **dependents**, a **dependent's** coverage will end on the earliest of the date:

- They are no longer a **dependent**
- Your coverage ends
- The period ends for which premium is paid
- This **policy** terminates

Refund Of Premium

A refund of premium will be made only in the event:

- Of your death
- You enter full-time active duty in any Armed Forces, and we receive proof of such active-duty service

Extension Of Benefits

If you are confined in a **hospital** for a medical condition on the date your coverage under this **policy** is terminated, expenses incurred during the continuation of that **hospital** stay will be considered a **covered expense**, but only while such expenses are incurred during the 90-day period following the termination of insurance. We will not continue to pay these **covered expenses** if:

- Your medical condition no longer continues
- You reach any maximum that may apply
- You obtain other coverage
- The **covered expenses** are incurred more than 3 months following termination of insurance

Continuation Of Coverage

A **covered person** who has been insured under this **policy** may continue to be insured under this **policy** when coverage terminates subject to the following:

- Continuation of coverage is available to **students** and their covered **dependents**, when the **student** leaves school, dies, or when the covered **dependent** no longer qualifies as an eligible **dependent**.
- The **covered person** requesting coverage must have been insured under this policy for at least 4 months.
- Requests for continuation of coverage, with the applicable premium, must be mailed to us, within 30 days of:
  - The date the existing coverage would otherwise terminate
  - The date the **covered person** is notified by us or the school of the right to continue the coverage
- Coverage and **benefits** will be the same as those which are applicable prior to continuation.
- Premium rates for continuation of coverage may be higher than student **rates**. Rates, and forms to request continuation of coverage, are available from us.
- The maximum period for which coverage may be continued is 6 months.
- Continuation of coverage is not available to persons who are eligible for coverage under another health care plan, including Medicare.

ACCIDENT AND MEDICAL EXPENSE BENEFITS

We will pay the **covered expenses** as shown on your **SCHEDULE OF BENEFITS** if you require 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 on your **SCHEDULE OF BENEFITS** 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** will be paid as shown on your **SCHEDULE OF BENEFITS**. If an **injury** or **sickness** requires multiple surgical procedures, we will cover according to the **allowable amount** shown on your **SCHEDULE OF BENEFITS**.
- 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 on your **SCHEDULE OF BENEFITS**.
- 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.
- **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** will be paid as shown on your **SCHEDULE OF BENEFITS**. If an **injury** or **sickness** requires multiple surgical procedures, we will cover according to the **allowable amount** shown on your **SCHEDULE OF BENEFITS**.

- 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** 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 address major **injuries** of the jaws, cheeks, lips, tongue, roof, and floor of the mouth, due to accident or disease
  - Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses)
  - Treatment of fractures of facial bone
  - External incision and drainage of cellulitis
  - Incision of accessory sinuses, salivary glands, or ducts
  - Reduction of dislocation of, or excision of, the temporomandibular joints.

  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

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

- 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**

- **Doctor's** Visits: **Benefits** will be paid as shown on your **SCHEDULE OF BENEFITS** when you visit your **physician's** office, or when your **physician** comes to your home. **Doctor** visits related to **surgery,** physical, occupational or **speech therapy** or chiropractic and osteopathic manipulation or diagnostic services, CT scans, PET scans or MRIs will be paid as a covered **outpatient** expense as shown on your **SCHEDULE OF BENEFITS**.

- **Physical therapy**, **occupational therapy**, 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 on your **SCHEDULE OF BENEFITS** 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**, including proton beam therapy: A higher standard of clinical evidence for the coverage of proton beam therapy shall not be higher than for the coverage of any other form of radiation treatment.

- Electroconvulsive Therapy

- Renal Dialysis Treatments: if received in a **hospital**, a **dialysis facility**, or in your home under the supervision of a **hospital** or **dialysis facility**

- 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 a **covered expense** as shown on your **SCHEDULE OF BENEFITS**. **Benefits** for physicians will be paid as a covered outpatient expense as shown on your **SCHEDULE OF BENEFITS**. **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) and 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 include, 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, and 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**, **copayment**, or **coinsurance** amount 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.

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 **GLOSSARY** section of this **policy**, those terms will apply only to their use in this **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:

- Placing the health of the individual, or with respect to a pregnant woman her unborn child, in serious jeopardy
- Constituting a serious impairment to bodily functions
- 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
- **Covered services** you receive from a **non-participating provider** during the same visit after your **emergency medical condition** has stabilized unless:
  - Your **non-participating provider** determines you can travel by non-medical or non-emergency transport
  - Your **non-participating provider** has provided you with a notice to consent form for balance billing of services
  - 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 services**, 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)
- **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**. Additionally, under Illinois law, in the event there is a payment dispute between a non-participating **provider** and BCBSIL and attempts to negotiate a payment resolution are unsuccessful within 30 days, the non-participating **provider** or BCBSIL may initiate binding arbitration by filing a request with the Department of Insurance. The requesting party shall notify the non-requesting party that arbitration has been initiated, along with its final offer for settlement. The non-requesting party must also share its final offer with the requesting party before arbitration occurs. In the event there is still no resolution regarding the payment of services, the parties may move forward in the arbitration process with an impartial third-party arbiter pursuant to the provisions in 215 ILCS 5/356z.3a.

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 maximum**, 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**.

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
- You are determined to be terminally ill

A serious and complex condition is one that:

- 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)
- For a chronic illness or condition, is life-threatening, degenerative, disabling or potentially disabling, or congenital, and 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**.

ADDITIONAL BENEFITS

Additional Surgical Opinion

Your coverage includes **benefits** for an additional surgical opinion following a recommendation for elective **surgery**. Your **benefits** will be limited to one consultation and related **diagnostic service** by a **physician**. **Benefits** for an additional surgical opinion consultation and related **diagnostic service** will be provided at 100% of the **claim charge**. Your **deductible** will not apply to this **benefit**. If you request, **benefits** will be provided for an additional consultation when the need for **surgery**, in your opinion, is not resolved by the first arranged consultation.

Ambulance Service

Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other means of transportation. When receiving **benefits** for **ambulance transportation** related to **emergency care**, you will not be responsible for amounts other than those listed on your **SCHEDULE OF BENEFITS**.

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**.

Autism Spectrum Disorders

Your **benefits** for the diagnosis and treatment of **autism spectrum disorder(s)** are the same as your **benefits** for any other condition. Treatment for **autism spectrum disorder(s)** shall include the following care when prescribed, provided, or ordered for an individual diagnosed with an **autism spectrum disorder** 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:
    - Self-care and feeding
    - Pragmatic, receptive and expressive language
    - Cognitive functioning
    - Applied behavior analysis (ABA), intervention and modification
    - Motor planning
    - Sensory processing

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

Bariatric Surgery

Benefits for **covered services** received for bariatric **surgery** will be covered the same as any other condition.

Blood And Blood Components

This plan provides **benefits** for the processing, transporting, storing, and administration of blood and blood components.

Breast Reduction Surgery

This plan provides **benefits** for **medically necessary** breast reduction **surgery**.

Cancer Clinical Trials Benefit

Benefits will be provided for routine patient care in conjunction with investigational treatments when medically appropriate and you have a terminal condition that according to the diagnosis of your **physician** is considered a **life threatening disease or condition** if:

- You are a qualified individual participating in an **approved clinical trial** program
- 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 your coverage under this **policy** due to participation in an **approved clinical trial** program. You and your **physician** are encouraged to call the toll-free telephone number on the back of your **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 this **policy** notwithstanding and payable to the same extent as any other medical expenses covered by this **policy**.

Cardiac Rehabilitation Services

Your **benefits** for cardiac rehabilitation services are the same as your **benefits** for any other condition. **Benefits** will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield of Illinois approved programs. **Benefits** are available if you have a history of any of the following:

- Acute myocardial infarction
- Coronary artery bypass graft **surgery**
- Percutaneous transluminal coronary angioplasty
- Heart valve **surgery**
- Heart transplantation
- Stable angina pectoris
- Compensated heart failure
- Trans myocardial revascularization

Cleft Lip And Palate

Benefits will be provided for **medically necessary** treatment and care for cleft lip and palate for children under the age of 19.

Consultant Doctor Fees

Benefits will be provided for consultant **doctor** fees when requested and approved by the attending **doctor**.

Coordinated Home Health Care

Benefits include the following **covered services** you receive 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
- Oxygen and its administration

Limited to the following:

- Professional services of an RN, LPN, or LVN
- Medical social service consultations
- Health aide services while you are receiving covered nursing or therapy services
- Services of a licensed registered dietician or licensed certified nutritionist, when authorized by your supervising **physician** and when **medically necessary** as part of diabetes self-management training

Coordinated home health care is subject to the **prior authorization** guidelines set forth in this **policy**. No **benefits** are payable for the following:

- Dietician service, except as specified for diabetes self-management training
- Homemaker services
- Maintenance therapy
- **Speech therapy**
- Durable medical equipment
- Food or home-delivered meals
- Intravenous drugs, fluid, or nutritional therapy, except when you have received **prior authorization** from the plan for these services

Dental Treatment (Injury Only)

Benefits for dental treatment 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.

Detoxification

Benefits for **covered services** received for detoxification will be covered the same as any other condition.

Diagnostic Colonoscopies

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

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
- Compression sleeves to prevent or mitigate lymphedema
- 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.

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:

1. **First Episode Psychosis Treatment - Benefits** for coordinated specialty care for first episode psychosis treatment will be covered when provided by FIRST.IL **providers**.
2. **Assertive Community Treatment (ACT) - Benefits** for ACT will be covered when provided by DHS-Certified **providers**.
3. **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.

Emergency Services

If you 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 your **inpatient hospital** stay during which your condition is determined to be serious and therefore not permitting your safe transfer to an in-network **hospital** or other **in-network provider**. For that portion of your **inpatient hospital** stay during which your condition is determined not to be serious, **benefits** will be provided at 50% of the **allowable amount** for **covered services** if you are in a non-plan **hospital** in an emergency department, or at the **out-of-network provider hospital** payment level if you are in an out-of-network **hospital** in an emergency department. For you to continue to receive **benefits** at the **in-network hospital** payment level following an emergency admission to an out-of-network **hospital**, you must transfer to an in-network **hospital** or other **in-network provider** as soon as your condition is no longer serious. To identify plan **hospitals** or facilities, you should contact Blue Cross and Blue Shield of Illinois by calling the toll-free telephone number on the back of your **identification card** or visiting the Blue Cross and Blue Shield of Illinois 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.

Fertility Preservation Services

Benefits will be provided for **medically necessary standard fertility preservation services** when a necessary medical treatment **may directly or indirectly cause iatrogenic infertility** to you.

Fibrocystic Breast Condition

Benefits will be provided for **medically necessary** services related to fibrocystic breast condition.

Habilitative Services And Devices

Benefits for **habilitative services and devices** for your congenital, genetic, or early acquired disorder are the same as your **benefits** for any other condition if all of the following conditions are met:

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

Hearing Aids

Benefits will be provided for **hearing aids** for **covered persons** 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**
- **Hearing aid** repairs will be covered when deemed **medically necessary**.

Hippotherapy

Benefits will be provided for medically necessary services that incorporate equine movement as part of a therapeutic intervention, including **hippotherapy**.

Therapies To Treat Menopause

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

Hospice

Care and services performed under the direction of your attending **physician** in an eligible **hospital** hospice facility or in-home hospice program. Hospice services are subject to the **prior authorization** 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
- Treatment, solely for cosmetic reasons
- **Physical therapy**
- **Physician** visits
- Social and spiritual services
- 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
- 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 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 birthing parent is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs, or the maternal breast milk is contraindicated
- The milk has been determined to be **medically necessary** for the infant
- One or more of the following applies:
  - The infant's birthweight is below 1,500 grams
  - The infant has a congenital or acquired condition that places the infant at a high risk for developing necrotizing enterocolitis
  - The infant has infant hypoglycemia
  - The infant has congenital heart disease
  - The infant has had, or will have, an organ transplant
  - The infant has sepsis
  - The infant has any other serious congenital or acquired condition for which the use of donated 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 the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com.

Human Organ Transplants

Your **benefits** for certain human organ transplants are the same as your **benefits** for any other condition. **Benefits** will be provided only for cornea, kidney, bone marrow, heart valve, 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 you are 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 you and the donor. In this case, payments made for the donor will be charged against your **benefits**.
- If you are the donor for the transplant and no coverage is available to you from any other source, the **benefits** under this **policy** will be provided for you. However, no **benefits** will be provided for the recipient.

Benefits will be provided for:

- **Inpatient** and **outpatient covered services** related to the transplant **surgery**
- The evaluation, preparation, and delivery of the donor organ
- The removal of the organ from the donor
- The transportation of the donor organ to the location of the transplant **surgery**

Benefits will be limited to the transportation of the donor organ in the United States or Canada. In addition to the above provisions, **benefits** for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants will be provided as follows:

- Whenever a heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplant is recommended by your **physician**, you must contact Blue Cross and Blue Shield of Illinois by telephone before your transplant **surgery** has been scheduled. Blue Cross and Blue Shield of Illinois will furnish you 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 you are the recipient of the transplant, **benefits** will be provided for transportation and lodging for you and one or two companions. For **benefits** to be available, your place of residency must be more than 50 miles from the **hospital** where the transplant will be performed. 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:
  - Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a hospital for transplant **surgery**
  - Transportation by air ambulance for the donor or the recipient
  - Travel time and related expenses required by a **provider**
  - Drugs which do not have approval of the Food and Drug Administration
  - Storage fees
  - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision
  - Meals

Infertility Diagnosis and Treatment

Benefits will be provided the same as your **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, surgical sperm extraction procedures, low tubal ovum transfer, and intracytoplasmic sperm injection. This coverage also includes procedures necessary to screen or diagnose a fertilized egg, before implantation, for aneuploidy, chromosome structural rearrangements, and monogenic or single gene disorders.

Benefits for the diagnosis and/or treatment of infertility described above are subject to the following conditions:

- They are determined to be **medically necessary** by your **provider**, based on clinical guidelines and standards developed by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the Society for Assisted Reproductive Technology
- They are performed at facilities that are members in good standing of the Society for Assisted Reproductive Technology

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility, or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy. The one year requirement will be waived if your **physician** determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to **chemotherapy** or radiation treatments, or efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between individuals 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 expense **benefits** will be paid for **outpatient** expenses only when:

- You have 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 you or your partner have 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**.

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

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

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 you will be covered if you choose to use a surrogate
- Selected termination of an embryo; provided, however, termination will be covered where the birthing parent's life would be in danger if all embryos were carried to full term
- Expenses incurred for cryo-preservation or storage of sperm, eggs, or embryos, except for those procedures which use a cryo-preserved substance. 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 your 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
- Infertility treatment rendered to your **dependents** under age 18

Mammograms

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

- One baseline mammogram
- An annual mammogram

Benefits for routine mammograms will be provided for individuals 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 individuals 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 or not 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 following a mastectomy for the length of time determined by your attending **physician** to be **medically necessary** and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation, and a follow-up **physician** office visit or in-home nurse visit within 48 hours after discharge
- Prostheses and physical complications of all stages of the mastectomy including, but not limited to lymphedemas
- The removal of breast implants when the removal of the implants is a **medically necessary** treatment for a **sickness** or **injury**. **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**.

Maternity Services

We 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
- A minimum of 96 hours of **inpatient** care following delivery by cesarean section

Your **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 birthing parent, determines that an early discharge is medically appropriate, we 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 birthing parent. 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
- Routine well-baby care:
  - While the baby is **hospital confined**
  - For routine nursery care provided within the first 31 days after birth, including treatment of diagnosed congenital and birth abnormalities, including **medically necessary** treatment and care for cleft lip and palate

If your **provider** determines you are experiencing a high-risk pregnancy, you will have access to clinically appropriate case management programs.

As used in this section, case management means the coordination and assurance of continuity of services, including, but not limited to health services, social services, and educational services necessary for the individual. Case Management involves an individualized assessment of needs, planning of services, referrals, monitoring, and advocacy to assist the individual in gaining access to appropriate services and closure when services are no longer required. This includes close coordination and involvement with all service **providers** in the management plan, including assuring that the individual receives the services needed.

Medical Benefit Therapeutic Alternatives

Certain **prescription drugs** administered by a health care professional have therapeutic equivalents or therapeutic alternatives that are used to treat the same condition. **Benefits** may be limited to only certain therapeutic equivalents or therapeutic alternatives. However, **benefits** may be provided for the therapeutic equivalents or therapeutic alternatives that are not otherwise covered under your **benefit** if an exception is granted.

You may contact Customer Service at the toll-free telephone number on the back of your **identification card** or visit www.bcbsil.com/find-care/medical-rx for more information about covered therapeutic equivalents or therapeutic alternatives. To request an exception, you, your prescribing health care **provider**, or your authorized representative, can call the toll-free telephone number on the back of your **identification card**.

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

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**. **Benefits** for the diagnosis and/or treatment of a **mental illness** and/or **substance use disorder** includes pregnancy and postpartum periods and are available for those who have experienced a miscarriage or stillbirth. 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 **prior authorization** guidelines, if any, set forth in this **policy**.

Mobile Integrated Health Care Services

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

Naprapathic Service

Benefits will be provided for **naprapathic services** when rendered by a **naprapath**.

Non-Emergency Fixed-Wing Ambulance Transportation

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

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, and those determined by your **provider** to be most appropriate for physical activities such as running, biking, swimming, and lifting. In addition, **benefits** will be provided for adjustments, repairs, or replacement of the device because of a change in your physical condition, as **medically necessary**.

Other Reproductive Health Services

Your coverage includes **benefits** for abortion care. **Benefits** for abortion care will be provided at no cost. No restrictions or delays will be imposed.

Pediatric Neuromuscular, Neurological, or Cognitive Impairment

Benefits will be provided for therapy, diagnostic testing, and equipment necessary to increase the quality of life for children who have been diagnosed with a disease, syndrome, or disorder that includes low tone neuromuscular, neurological, or cognitive impairment.

Pediatric Palliative Care

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

Private Duty Nursing Service

Benefits for private duty nursing service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care **provider**. No **benefits** will be provided when a nurse ordinarily resides in your home or is a member of your **immediate family**. Private duty nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment 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 services are subject to the **prior authorization** guidelines set forth in this **policy**.

Pulmonary Rehabilitation Therapy

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

Reconstructive Services

Benefits will be provided for **medically necessary** reconstructive services to restore physical appearance due to trauma.

Routine Liver Screening

Benefits will be provided every six months at no charge for routine liver screenings, including liver ultrasounds and alpha-fetoprotein blood tests for individuals who are high risk for liver disease.

Routine Pediatric Hearing Examination

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

Skilled Nursing Facility

Benefits will be provided for covered **inpatient hospital** services and supplies given to an **inpatient** of an eligible skilled nursing facility. Subject to the **prior authorization** guidelines set forth in this **policy**. No **benefits** are payable:

- Once you can no longer improve from treatment
- For custodial care or care for your 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.

Sterilization Procedures

Benefits for covered sterilization procedures and follow-up services will be provided at no charge when received from a participating **provider**.

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

prior authorization guidelines, if any, set forth in this **policy**.

Tests And Procedures

Benefits are provided for **diagnostic services** and medical procedures performed by a **doctor**, other than **doctor's** visits, **physical therapy**, 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, including **medically necessary** home saliva cancer screenings once every twenty-four (24) months if you are at high risk or showing symptoms of the disease being tested for.

1. **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.
2. **Pancreatic Cancer Screening**
   Benefits will be provided for **medically necessary** pancreatic cancer screenings.
3. **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.
4. **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.

Telehealth And Telemedicine Services

Benefits are provided for **medically necessary telehealth and telemedicine services**.

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**.

Vaginal Estrogen

Benefits will be provided for covered vaginal estrogen products, or FDA-approved therapeutic equivalents, when determined to be **medically necessary**.

Virtual Visits

If **virtual visits** are listed on your **SCHEDULE OF BENEFITS**, **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 the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com.

Benefits for **covered services** you receive through a **virtual visit** will be provided at the payment level shown on your **SCHEDULE OF BENEFITS**. **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.

Wigs

Benefits will be provided for one wig per **benefit period** (also referred to as a cranial prostheses) for hair loss caused by:

- Chemotherapy
- Radiation treatment for cancer or other conditions
- Alopecia

OUTPATIENT PRESCRIPTION DRUG PROGRAM

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 to keep up with changes in prices, pharmaceutical manufacturer recalls, or other safety concerns. Blue Cross and Blue Shield of Illinois may offer multiple **drug lists**. You 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 you receive. 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 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 and your prescribing **provider** (or authorized representative) know the coverage decision within 72 hours 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, you may appeal the decision.

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.

Some drugs under your plan may be subject to certain supply/fill limitations pursuant to diagnoses or new-to-therapy requirements, plan design, and/or state or federal regulations. For specific drugs supply/fill information, please call the Customer Service toll-free telephone number on the back of your identification card.

Topical Eye Medications

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.

Prescription Inhalants

Benefits for **medically necessary** prescribed inhalers for those with asthma or other life-threatening bronchial ailments. Cost sharing for this coverage will not exceed $25 per 30-day supply, when obtained from a **participating pharmacy**.

Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill can be obtained.

Controlled Substance Limitation

If Blue Cross and Blue Shield of Illinois determines that you may be receiving quantities of **controlled substance** medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether **medically necessary** 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 you do not choose the therapeutic equivalents that are covered under this **benefit** section, the drug purchased will not be covered under any **benefit** level.

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

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** requirement provision above) for **prescription drugs** have been met
- The **prescription drugs** can be safely split into short-fill periods to achieve synchronization
- The **prescription drugs** do not have special handling or sourcing needs that require a single, designated **pharmacy** to fill or refill the prescription

When necessary to permit synchronization, 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 on your **SCHEDULE OF BENEFITS**.

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 within 120 days, 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.

MedsYourWay™

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

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

Retail Pharmacy

The **benefits** you receive and the amount you pay will differ depending upon the tier and type of drugs, diabetic supplies, or insulin and insulin syringes obtained and whether they are obtained from a participating **pharmacy** or **non-participating pharmacy**.

When you obtain covered drugs (other than **specialty drugs**), including diabetic supplies from a participating **pharmacy**, **benefits** will be provided as shown on your **SCHEDULE OF BENEFITS**.

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 on your **SCHEDULE OF BENEFITS** 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 on your **SCHEDULE OF BENEFITS** 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.

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.

The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $35, when obtained from a preferred participating or participating pharmacy.

The amount you may pay for a twin-pack of medically necessary epinephrine injectors, regardless of type, shall not exceed $60, when obtained from a participating pharmacy**.**

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**.

Abortifacients

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

Blood Glucose Monitors for Treatment of Diabetes

This plan provides **benefits** for **medically necessary** blood glucose monitors (including continuous glucose monitors, non-invasive monitors, and monitors for the blind), if a **physician** has provided a written order. This coverage also includes related supplies, and training in the use of continuous glucose monitors.

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

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**, 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-participating specialty pharmacy** or **non-participating pharmacy** will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

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
- Continuous glucose monitors and associated supplies
- Glucagon emergency kits

Fertility Drugs

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

HIV Post-Exposure Prophylaxis

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

Hormonal Therapy for Gender Dysphoria

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

Therapies to Treat Menopause

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

Immunosuppressant Drugs

Benefits are available for immunosuppressant drugs prescribed in connection with a human organ transplant. If your **provider** indicates "MAY NOT SUBSTITUTE" on a prescription for immunosuppressant drugs, BCBSIL will not require the pharmacy to dispense another immunosuppressant drug or formulation without notification and consent from you and your **provider**.

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**.

Inherited Gene Mutation Testing

Benefits will be provided for **outpatient** clinical genetic testing for an inherited gene mutation for those with a personal or family history of cancer, or for evidence-based screenings for those with an inherited mutation, associated with an increased risk of cancer when recommended by a **provider**. Cost sharing for this coverage will not exceed $50 per test, when obtained from a participating **provider**.

Intranasal Opioid Reversal Agents

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

NOTE: Benefits for naloxone hydrochloride will be provided at no charge when obtained from a participating pharmacy.

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.

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.

NOTE: Benefits for naloxone hydrochloride, will be provided at no charge, when obtained from a **participating pharmacy**.

Opioid Medically Assisted Treatment

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

Pregnancy Tests

Benefits will be provided for up to two (2) pregnancy tests every thirty (30) days, when prescribed for at home use.

Prenatal Vitamins

Benefits will be provided for prenatal vitamins, when prescribed by a **physician** or advanced practice nurse.

Specialty Drugs

In order to receive maximum **benefits** for **specialty drugs**, you 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 on your **SCHEDULE OF BENEFITS** you would have received had you obtained drugs from a **specialty pharmacy provider** and will not apply to your deductible.

Topical Anti-Inflammatory Acute and Chronic Pain Medications

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.

Vaccinations, Testing, Screening, and Treatment obtained through Participating Pharmacies

Benefits for select covered vaccinations, including testing, screening, and treatments 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 the Blue Cross and Blue Shield of Illinois 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 you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under the **OUTPATIENT PRESCRIPTION DRUG PROGRAM**. You can refer to your 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, including the administrative fee, will not be subject to any **deductibles**, **copayments**, coinsurance, 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 non-participating pharmacists, or other routine covered services not provided for under this provision may be subject to the **deductibles**, **copayments**, **coinsurance**, and/or **benefit** maximums.

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**, **copayment**, **coinsurance**, 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:

- 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")
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC") with respect to the individual involved
- 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
- 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 you.

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.

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you can call the toll-free telephone number on the back of your **identification card** or visit the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com.

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**, **copayment**, **coinsurance**, or dollar maximum.

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 intervention
- Colorectal cancer screening for adults over age 45, and a follow-up colonoscopy if the results of the initial test or procedure is abnormal
- Annual routine prostate-specific antigen test and digital rectal examination
- 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):
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster (Shingles)
    - Human papillomavirus
    - Influenza (Flu shot or Flu mist)
    - Measles, Mumps, Rubella
    - Meningococcal
    - MPOX
    - Pneumococcal
    - RSV
    - Tetanus, Diphtheria, Pertussis
    - Haemophilus influenzae type b (Hib)
    - Varicella
    - COVID-19
- 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
- A1C testing for prediabetes, type I diabetes, and type II diabetes, in accordance with the prediabetes and diabetes risk factors identified by the United States Centers for Disease Control and Prevention
- 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) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking) and (c) a calculated 10-year CVD risk of 10% or greater
- Tuberculin testing for adults 18 years or older who are at a higher risk of tuberculosis
- Whole body skin examination for lesions suspicious for skin cancer
- Mental Health prevention and wellness visit

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

- Bacteriuria urinary tract screening or other infection screening for pregnant persons
- BRCA counseling about genetic testing for women at higher risk, and if recommended by a **provider** after counseling, BRCA genetic testing
- 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. Also covers additional imaging and pathology evaluation if indicated to complete the initial screening for malignancies.
- 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
- Annual ovarian cancer screening for women using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination
- Chlamydia infection screening for younger women, pregnant persons, 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 and pregnant persons
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling for pregnant persons 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. The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years.
- Osteoporosis screening for women over age 60, depending on risk factors
- Vitamin D testing in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention
- 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 pregnant persons, 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
- Annual routine cervical smear or pap smear test for women
- 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 persons to prevent preeclampsia
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
- Menopause health visit

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):
    - Diphtheria, Tetanus, and Acellular Pertussis
    - Haemophilus influenzae type b (Hib)
    - Hepatitis A
    - Hepatitis B
    - Human papillomavirus (HPV)
    - Inactivated Poliovirus
    - Influenza (Flu shot or Flu Mist)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - RSV
    - Varicella
    - COVID-19
- Lead screening for children at risk for exposure
- Autism screening
- 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.
- Whole body skin examination for lesions suspicious for skin cancer
- Mental health prevention and wellness visit

Preventive drugs (including both prescription and over the counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive 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 **deductibles**, **copayments**, **coinsurance**, or dollar maximum when obtained from a participating pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a **non-participating pharmacy**, may be subject to **deductibles**, **copayments**, **coinsurance**, or dollar maximums, if applicable.

A Copayment waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

The FDA approved contraceptive drugs and devices currently covered under this **benefit** provision are listed on the *Women's Contraceptive Coverage List.* This list is available on the Blue Cross and Blue Shield of Illinois 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*. You may, however, have coverage under other sections of this **policy**, subject to any applicable **deductibles**, **copayments**, **coinsurance**, and/or **benefit** maximums. The *Women's Contraceptive Coverage List* and the preventive care services covered under this **benefit** provision are subject to change as FDA guidelines, medical management, and medical policies are modified.

Routine pediatric care, women's preventive care (such as contraceptives) and/or **outpatient** periodic health examinations **covered services** not included above will be subject to the **deductibles**, **copayments**, **coinsurance**, 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 **deductibles**, **copayments**, **coinsurance**, and/or **benefit** maximums.

If your 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 **deductibles**, **copayments**, **coinsurance** and/or dollar maximum, if applicable.

Benefits for vaccinations that are considered preventive care services will not be subject to any **deductibles**, **copayments**, **coinsurance**, and/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 pharmacy**, or other routine **covered services** not provided for under this provision may be subject to the **deductibles**, **copayments**, **coinsurance**, and/or **benefit** maximums.

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for **deductibles**, **copayments**, and/or **coinsurance** 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, you may be responsible for **deductibles**, **copayments**, and/or **coinsurance** amounts for the office visit including the preventive health service.

PEDIATRIC VISION CARE

Only for Covered Persons under the age of 19

This **PEDIATRIC VISION CARE** section is made part of and is in addition to any information you may have in this **policy**. This **PEDIATRIC VISION CARE** section provides information about coverage for the routine vision care services outlined below, which are specifically excluded under your medical/surgical **benefits** of this **policy**. **(Services that are covered under your medical/surgical benefits of this policy are not covered under this PEDIATRIC VISION CARE section.) All provisions in this policy apply to this section unless specifically indicated otherwise below.**

This BCBSIL pediatric vision care plan allows you to select the **provider** of your choice, either an EyeMed contracting **provider**, or a non-contracting **provider**. BCBSIL has designed **benefit** plans to deliver quality care, matched with comprehensive **benefits**, at the most affordable cost, through EyeMed contracting **providers**. You will have a higher **benefit** level if you choose to receive pediatric vision care services from an EyeMed contracting **provider**.

Definitions

Benefit Period - For purposes of this **PEDIATRIC VISION CARE** section, a period of time that begins on the later of:

- The **covered person's** effective date of coverage
- The last date a vision examination was performed on the **covered person** or that **vision materials** were provided to the **covered person**, whichever is applicable. (A **benefit period** does not coincide with a calendar year and may differ for each **covered person**.)

Provider - For purposes of this **PEDIATRIC VISION CARE** section, a licensed ophthalmologist, optometrist, or therapeutic optometrist operating within the scope of their license, or a dispensing optician.

Vision Materials - Corrective lenses and/or frames or contact lenses

Eligibility

Children who are covered under this **policy's** medical/surgical **benefits**, up to age 19, are eligible for coverage under this **PEDIATRIC VISION CARE** section. **NOTE:** Once coverage is lost under the medical/surgical **benefits** of this **policy**, all **benefits** cease under this **PEDIATRIC VISION CARE** section. Extension of **benefits** due to disability, state or federal continuation coverage, and conversion option privileges are **not** available under this **PEDIATRIC VISION CARE** section.

Limitations and Exclusions

In addition to the general limitations and exclusions listed in this **policy**, this **PEDIATRIC VISION CARE** section does not cover services or materials connected with or charges arising from:

- Any vision service, treatment or materials not specifically listed as a **covered service**
- Services and materials not meeting accepted standards of optometric practice
- Services and materials resulting from your failure to comply with professionally prescribed treatment
- Services rendered after the date a **covered person** ceases to be covered under this **policy**, except when **vision materials** ordered before coverage ended are delivered, and the services rendered to the **covered** person are within 31 days from the date of such order
- Telephone consultations
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances
- Office infection control charges
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts
- State or territorial taxes on vision services performed

- Medical treatment of eye disease or **injury**
- Visual therapy
- Special lens designs or coatings other than those described in this section
- Replacement of lost/stolen eyewear
- Non-prescription (Plano) lenses
- Non-prescription sunglasses
- Two pairs of eyeglasses in lieu of bifocals
- Services not performed by licensed personnel
- Prosthetic devices and services
- Insurance of contact lenses
- Professional services you receives from immediate relatives or household members, such as a spouse, including **domestic partner**, parent, child, brother, or sister, by blood, marriage, or adoption
- Services covered under the medical/surgical **benefits** of this **policy**
- Replacement of lost, stolen, damaged, or broken materials, until the next **benefit** frequency when **vision materials** would next become available
- Services of unlicensed personnel
- Orthoptic or vision training
- Aniseikonic spectacle lenses
- Any eye or vision examination, or any corrective eyewear required by policyholder as a condition of employment or safety eyewear
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency program whether federal, state, or subdivisions thereof

How the Vision Care Plan Works

Under the vision care plan option, you may visit any **provider** and receive **benefits** for a vision examination. In order to maximize benefits for most covered **vision materials**, however, you must purchase them from an EyeMed contracting **provider**.

Before you go to an EyeMed contracting vision care **plan provider** for an eye examination, eyeglasses, or contact lenses, you should call ahead for an appointment. When you arrive, you should show the receptionist your **identification card**. If you forget to take your card, you should say that you are a member of the BCBSIL vision care plan so that your eligibility can be verified.

To locate an EyeMed contracting vision care **provider**, you can visit the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com or contact Customer Service at the toll-free telephone number on the back of your **identification card** to obtain a list of the EyeMed contracting vision care **plan providers** nearest you.

If you obtain glasses or contacts from a non-contracting **provider**, you must pay the **provider** in full and submit a **claim** for reimbursement (see the **CLAIM PROVISIONS** section of this **policy** for more information).

You may receive your eye examination and eyeglasses/contacts on different dates or through different **provider** locations, if desired. However, complete eyeglasses must be obtained at one time, from one **provider**. Continuity of care will best be maintained when all available services are obtained at one time from one EyeMed contracting **provider** and there may be additional professional charges if you seek contact lenses from a **provider** other than the one who performed your examination.

Fees charged for services other than a covered vision examination or covered **vision materials** and amounts in excess of those payable under this **PEDIATRIC VISION CARE** section, must be paid in full by you to the **provider**, whether or not the **provider** participates in the vision care plan network. **Benefits** under this section may not be combined with any discount, promotional offering, or other group **benefit** plans. Allowances are one-time use **benefits**; no remaining balances are carried over to be used later.

LIMITATIONS AND EXCLUSIONS

Except as specified in this **policy**, coverage is not provided for loss or charges incurred by or resulting from:

- Charges that are not **medically necessary** or in excess of the **allowable amount**
- Services that are provided, normally without charge, by the Student Health Center, infirmary, **hospital**, or by any person employed by the university
- Acupuncture procedures
- Breast augmentation or reduction
- Routine circumcision, unless the procedure is medically necessary for treatment of a sickness, disease or functional congenital disorder not excluded hereunder or as may be necessitated due to an **accident** or except for covered infants within 31 days of birth
- Non-malignant warts
- Moles
- Lesions
- Testing or treatment for sleep disorders
- Any charges for **surgery**, procedures, treatment, facilities, supplies, devices, or drugs that the Insurer determines are **experimental/investigational.** You may contact Customer Service at the toll-free telephone number on the back of your **identification card** for more information about what **experimental/investigational services or supplies** may be excluded.
- Clinical technology, services, procedures, and service paradigms designated by a temporary (CPT® Category III) code are not covered, except for certain services otherwise specified by state or federal law, or federal coverage or billing guidelines.
- Expenses incurred for **injury** or **sickness** arising out of or in the course of your employment, regardless of if **benefits** are, or could be paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation
- This plan does not cover cannabis. Cannabis means all parts of the plant genus cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds, or its resin. Cannabis with THC as an active ingredient may be called marijuana.
- Treatment, services or supplies in a Veteran's Administration or **hospital** owned or operated by a national government or its agencies unless there is a legal obligation for you to pay for the treatment
- Expenses in connection with services and prescriptions for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses, radial keratotomy or laser **surgery** for vision correction or the treatment of visual defects or problems, except for pediatric vision
- Sinus or other nasal **surgery**, including correction of a deviated septum by submucous resection and/or other surgical correction, except for a covered **injury**
- Reconstructive **surgery**, **plastic surgery**, cosmetic **surgery**, or complications resulting therefrom, including **surgery** to improve or restore your appearance, unless:
  - Needed to repair conditions resulting from an accidental **injury**
  - For the improvement of the physiological functioning of a malformed body member resulting from a congenital defect
  - For the treatment provided for reconstructive **surgery** following cancer **surgery**

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a **covered service** unless such care and services are performed solely and directly as a result of mastectomy which is **medically necessary**
- Riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline
- **Injury** resulting from racing or speed contests, skin diving, sky diving, parachuting, hang gliding, glider flying, parasailing, sailplaning, bungee jumping, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby

- War, or any act of war, whether declared or undeclared or while in service in the active or reserve Armed Forces
- Any expenses incurred in connection with sexual dysfunctions , sterilization reversal or vasectomy reversal
- Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to covered oral **surgery** or the repair of Injuries to sound natural teeth caused by a covered **injury**
- Hirsutism
- Alopecia
- Gynecomastia
- Weight management, weight reduction, or treatment for obesity including any condition resulting therefrom, including hernia of any kind
- **Surgery** for the removal of excess skin or fat
- Nutrition programs, except as related to treatment for diabetes
- Custodial care
- Long term care service
- Weight loss programs
- Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy

Prescription Drug coverage is not provided for:

- Refills in excess of the number specified or dispensed after one (1) year from the date of the prescription
- Drugs labeled "Caution - limited by federal law to investigational use" or experimental drugs
- Drugs determined to have inferior efficacy or significate safety issues
- Immunizing agents, biological sera, blood, or blood products administered on an **outpatient** basis, except as specifically provided in this **policy**
- Any devices, appliances, support garments, hypodermic needles except as used in the administration of insulin, or non-medical substances regardless of their intended use
- Drugs used for cosmetic purposes, including but not limited to Retin-A for wrinkles, Rogaine for hair growth, anabolic steroids for body building, anorectics for weight control, etc.
- Sexual enhancement drugs, medications or supplies for the treatment of impotence and/or sexual dysfunction, including but not limited to: Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, Viagra, Cialis, or Levitra
- Lost or stolen prescriptions
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control
- Non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a **prescription order**. (Non-commercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.)
- Brand Name proton pump inhibitors
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation
- Drugs which are not included on the **drug list** unless specifically covered elsewhere in this **policy** and/or such coverage is required in accordance with **applicable law** or regulatory guidance
- Select medications may be excluded from the medical **benefit** when a self-administered formulation of the product is available.

Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit **benefits** to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your **benefit**, the drug purchased will not be covered under any **benefit** level.

Some laboratory services are not covered by your plan. The following laboratory services are not covered:

1. **Allergen Testing:**
   a. Routine re-testing for confirmed allergies to the same allergies except in children and adolescents with positive food allergen results to monitor for food allergy resolution
   b. The Antigen Leukocyte Antibody test (ALCAT)
   c. In-vitro testing of allergen specific IgG or non-specific IgG, IgA, IgM, and/or IgD in the evaluation of suspected allergy
   d. Basophil Activation flow cytometry testing for measuring hypersensitivity to allergens
   e. In-vitro allergen testing using bead-based epitope assays
   f. In-vitro testing of allergen non-specific IgE

2. **Cardiovascular Disease Risk Assessment Testing:**
   a. High-sensitivity C-Reactive Protein except when a risk-based treatment decision is not certain after having a quantitative risk assessment using American College of Cardiology/American Heart Association (ACC/AHA) calculator to calculate 10-year risk of Cardiovascular disease CVD
   b. High-sensitivity C-Reactive Protein as a screening test for the general population or for monitoring response to therapy
   c. High-sensitivity cardiac troponin T for cardiovascular risk assessment and stratification in the outpatient setting
   d. Homocysteine testing for cardiovascular disease risk assessment screening, evaluation and management
   e. Novel Cardiovascular Biomarkers such as measurement of novel lipid and non-lipid biomarkers as an add on to LDL cholesterol in the risk assessment of cardiovascular disease
   f. Cardiovascular risk panels, consisting of multiple individual biomarkers intended to assess cardiac risk (other than simple lipid panels)
   g. Serum Intermediate Density Lipoprotein as an indicator of cardiovascular disease risk
   h. Measurement of lipoprotein-associated phospholipase as an indicator of risk of cardiovascular disease
   i. Measurement of secretory type II phospholipase in the assessment of cardiovascular risk for all indications
   j. Measurement of long-chain omega-3 fatty acids in red blood cell membranes, including but not limited to its use as a cardiac risk factor
   k. All other tests for assessing cardiovascular health disease risk

3. **Cervical Cancer Screening:**
   a. Cervical cancer screening and testing for HPV more than one time per calendar year when:
      i. Testing for high-risk strains of HPV-16 and HPV-18 unless both cytology negative and HPV positive co-testing criteria are present
      ii. Testing on individuals that have no history of cervical cancer or pre-cancer and that do not have a uterus and cervix
      iii. Inclusion of low-risk strains of HPV in co-testing
   b. Other technologies are used for cervical cancer screening

4. **Drug testing:** Except where testing is rendered in an urgent/emergency situation or as a component of routine physical/medical exam or related to surgery or medical care, drug testing is not covered in an outpatient setting in the following situations:

a. Testing to confirm the presence and/or amount of drugs in your system when laboratory-based definitive drug testing is requested without any prior screening test results, or when laboratory-based definitive drug testing is requested for larger than seven drug class panels
b. Use of proprietary drug tests such as CareView360
c. Specific validity testing, including, but not limited to urine specific gravity, urine creatinine, Ph, urine oxidant level, and genetic identify testing are included in the panel test - these tests will not be covered if submitted individually and when a urine panel test was also ordered at the same time
d. Testing for any American Medical Association definitive drug class codes
e. Same-day testing for the same drug or metabolites from two different samples (e.g., both a blood and a urine specimen)
f. Testing of samples with abnormal validity tests
g. Drug testing for patients in a facility setting (inpatient or outpatient) are not separately covered, as they are included in the daily charge at the facility
h. Both qualitative (type of drug) testing and presumptive (verification of presents of drugs) testing on the same specimen

5. Folate Testing:
a. Measurement of red blood cell (RBC) folate
b. Measurement of serum folate concentration unless the individual is has been diagnosed with megaloblastic or macrocytic anemia and those conditions do not resolve after folic acid treatment
c. Folate receptor autoantibody testing

6. Hemoglobin A1c: Hemoglobin A1c testing in the following situations:
a. If an individual has had a blood transfusion in the last 120 days
b. If an individual has a condition associated with increased red blood cell turnover
c. If an individual is also being measured for fructosamine

7. Iron Homeostasis and Metabolism:
a. Ferritin or transferrin measurement, including transferrin saturation, as a screening test in asymptomatic individuals
b. Serum hepcidin testing, including immunoassays
c. GlycA testing to measure or monitor transferrin or other glycosylated proteins

8. Pancreatic Enzyme Testing:
a. As part of an ongoing assessment of therapy for acute pancreatitis
b. To determine the prognosis of pancreatitis
c. To determine the severity or progression of pancreatitis
d. More than once per visit
e. For the diagnosis, prognosis, or severity of chronic pancreatitis
f. As part of an ongoing assessment or therapy of chronic pancreatitis
g. In asymptomatic nonpregnant individuals during general exam without abnormal findings
h. Measurement of serum or urine trypsin/trypsinogen/TAP (trypsinogen activation peptide) for the diagnosis, assessment, prognosis and/or determination of severity of acute pancreatitis
i. For the diagnosis, assessment, prognosis, and/or determination of severity of acute pancreatitis, measurement of the following biomarkers is not covered:
    i. C-Reactive Protein (CRP)
    ii. Interleukin-6 (IL-6)
    iii. Interleukin-8 (IL-8)
    iv. Procalcitonin
j. Measurement of urinary amylase concentration for the initial diagnosis of acute pancreatitis for individuals presenting with signs and symptoms of acute pancreatitis

9. **Thyroid Disease:**
    a. Testing of reverse T3, T3 uptake and total T4 in individuals with no signs or symptoms consistent with hypothyroidism and who are not at high risk for thyroid disease
    b. Measurement of total T3 (TT3) and/or free T3 (fT3) for the assessment of hypothyroidism
    c. Measurement of total or free T3 level to assess levothyroxine in hypothyroid individuals
    d. Testing in asymptomatic nonpregnant individuals for thyroid dysfunction during a general exam without abnormal findings

10. **Vitamin B12:**
    a. Testing or screening for a Vitamin B12 deficiency in a healthy, asymptomatic individual
    b. Homocysteine or holotranscobalamin testing to screen for or to confirm a Vitamin B12 deficiency
    c. Vitamin B12 testing within three (3) months of beginning treatment for a B12 deficiency

11. **Vitamin D Testing:**
    a. Routine screening for Vitamin D deficiency with serum testing in asymptomatic individuals and/or during general encounters. Risk factors for Vitamin D deficiency include, but are not limited to:
        i. Having osteoporosis or other bone-health problems
        ii. Having conditions that affect fat absorption including celiac disease or weight loss surgery
        iii. Routinely taking medications that interfere with vitamin D activity, including anticonvulsants and glucocorticoids

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies to this benefit program when you have health care coverage under more than one benefit program. COB does not apply to the **OUTPATIENT PRESCRIPTION DRUG PROGRAM** section or the **PEDIATRIC VISION CARE** section.

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
- 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 **GLOSSARY** 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:

1. 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
2. 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 (1) or (2) 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:

1. The other benefit program has rules coordinating its benefits with those of this benefit program
2. 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 a dependent, except that, if the person is also a Medicare beneficiary, Medicare is:

a. Secondary to the benefit program covering the person as a dependent
b. 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"):

a. 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
b. 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:

a. First, the program of the parent with custody of the child
b. Then, the program of the spouse of the parent with custody of the child
c. 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 their 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:

a. First, the benefits of a benefit program covering the person as an employee, member, or subscriber (or as that person's dependent)
b. 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:

1. The benefits that would be payable for the allowable expenses under this benefit program in the absence of this COB provision
2. 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
- 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 this **policy**, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the **insured**, or their 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. Please submit **claims** to:

Blue Cross and Blue Shield of Illinois
300 East Randolph Street
Chicago, Illinois 60601-5099

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 this **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 you where you had paid any portion of a

medical bill that would be covered under terms of this **policy**.

Initial Claim 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, you 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 you, your valid assignee, or your authorized representative when all information required to process a **claim** in accordance with the terms of the **benefit** program within 30 days of the **claim's** receipt has not been received. If you fail to follow the procedures for filing a pre-service **claim** (as defined below), you 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 you request written notification.

If a Claim Is Denied or Not Paid in Full

If the **claim** for **benefits** is denied, you 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 your **claim** for **benefits**.
- 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 your **claim** for **benefits**, unless you fail to provide sufficient information. You 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 your life or health or your ability to regain maximum function or, in the opinion of a **physician** with knowledge of your medical condition, would subject you 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 you to obtain before you get **medical care**, such as **prior authorization** 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 **UTILIZATION MANAGEMENT** section of this **policy**.

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 you or your 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 you, the notice of extension shall also specifically describe the missing information, and you 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, you or your authorized representative shall be notified in writing of the following:

1. The reasons for denial
2. A reference to the **benefit** plan provisions on which the denial is based
3. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary
4. 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.

5. 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:
   a. 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)
   b. 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 below), and your **claim** was denied for one of these reasons:
      i. A decision about the medical need for or the experimental status of a recommended treatment
      ii. A condition was considered pre-existing
      iii. Your health care coverage was rescinded. For additional information, see **Rescission of Coverage** in the **GENERAL PROVISIONS** section of this **policy**, or 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.
   c. An explanation that you may ask for an expedited (urgent) external review if:
      i. 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
      ii. Blue Cross and Blue Shield of Illinois failed to give you a decision within 48 hours of your request for an expedited appeal
      iii. The request for treatment is **experimental/investigational** and your health care **provider** states in writing that the treatment would be much less effective if not promptly started
   d. 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 you received emergency services, but has not been discharged from a facility.
   e. 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.
   f. 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.
   g. 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).
   h. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the **claim** for **benefits**
   i. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request.
   j. An explanation of the scientific or clinical judgment relied on in the determination as applied to your medical circumstances. If the denial was based on **medical necessity**, experimental treatment or similar exclusion, a statement that such explanation will be provided free of charge upon request.

k. 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 you within 3 days of oral notification.
l. 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
Email: DOI.Complaints@illinois.gov
Web address: https://mc.insurance.illinois.gov/messagecenter.nsf

Illinois Department of Insurance
Office of Consumer Health Insurance
115 S. LaSalle Street, 13th Floor
Chicago, IL 60603
(312) 814-2420

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
Email: DOI.externalreview@illinois.gov
Web 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 you either orally or in writing.

Blue Cross and Blue Shield of Illinois has a team available to assist you with **inquiries** and **complaints**. Issues may include, but are not limited to the following:

- **Claims**
- Quality of care

When your **complaint** relates to the dissatisfaction with a **claim** denial (or partial denial), then you have the right to a **claim review**/appeal as described in **claim** appeal procedures.

To pursue an **inquiry** or **complaint**, you may call the toll-free telephone number on the back of your **identification card**, or you may write to:

Blue Cross and Blue Shield of Illinois
P.O. Box 660603
Dallas, TX 75266-0603

When you contact Customer Service to pursue an **inquiry** or **complaint**, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your **inquiry** or **complaint** within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If Blue Cross and Blue Shield of Illinois needs more information, you will be contacted. If a response to your **inquiry** or **complaint** will be delayed due to the need for additional information, you will be contacted.

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 you, or a person authorized to act on your behalf. In some circumstances, a health care **provider** may appeal on their own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an authorized representative form, you or your representative may call the toll-free telephone number on the back of your **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/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 your **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, 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
- A **rescission**. For additional information, see **Rescission of Coverage** in the **GENERAL PROVISIONS** section of this policy.

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 you have received an **adverse benefit determination**, you may have your **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:

- Coverage determinations that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximum your **benefits**

- Coverage determinations that are related to care that you are 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 you, or a person authorized to act on your behalf. In some circumstances, a health care **provider** may appeal on their own behalf. Under your health **benefit** plan, there is one level of internal appeal available to you. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an authorized representative form, you or your representative may call the toll-free telephone number on the back of your **identification card**. In urgent care situations, a **doctor** may act as your authorized representative without completing the form.

Within 180 days after you receive notice of an **adverse benefit determination**, you 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 you do not agree with the **adverse benefit determination**.

In support of your **claim review**, you have the option of presenting evidence and testimony to Blue Cross and Blue Shield of Illinois. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments, and additional medical information within 180 days after you receive notice of an **adverse benefit determination** or at any time during the **claim review** process.

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 660603
Dallas, TX 75266-0603
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 your internal appeal(s), Blue Cross and Blue Shield of Illinois will provide your 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 you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. Blue Cross and Blue Shield of Illinois may extend the time period described in this **policy** for its final decision on appeal to provide you 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 your **claim**. No deference will be given to the initial **adverse benefit determination**. Before the you or your authorized representative may bring any action to recover **benefits** you 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 your 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 your health, then you 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 you 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 render a determination of the appeal within 3 business days if no 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 You Need Assistance

If you have any questions about the **claims** procedures or the review procedure, you 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 660603
Dallas, TX 75266-0603

If you need assistance with the internal **claims** and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431 or call the toll-free telephone number on the back of your **identification card** for contact information.

Notice of Appeal Determination

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

The written notice will include:

1. The reasons for the determination
2. A reference to the **benefit** plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination
3. Subject to privacy laws and other restrictions, if any, the identification of the **claim**, date of service, health care **provider**, **claim** amount (if applicable), and a statement describing 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.

4. 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:
    - 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)
    - 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 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 the **GLOSSARY** section of this **policy**.
    - 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.
    - 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
        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
    - The **final adverse determination** concerns an admission, availability of care, continued stay or health care service for which you received **emergency services**, but have 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.
    - 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).
    - 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
    - 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**
    - 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.
    - 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.
    - 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 your **claim** or you do not receive a timely decision, you may be able to request an external review of your **claim** by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Independent External Review** section below.

If an appeal is not resolved to your satisfaction, you 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 you 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
320 West Washington Street
Springfield, IL 62767
Toll-free: (877) 527-9431
Fax: (217) 558-2083
Email: DOI.externalreview@illinois.gov
Web address: https://mc.insurance.illinois.gov/messagecenter.nsf

Illinois Department of Insurance
Office of Consumer Health Insurance
115 S. LaSalle Street, 13th Floor
Chicago, IL 60603
(312)814-2420

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

You 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 you have an adverse appeal determination, you may file civil action in a state or federal court.

Independent External Review

You or yours 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.

Standard External Review
You or your 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
Email: Doi.externalreview@illinois.gov
Web address: https://mc.insurance.illinois.gov/messagecenter.nsf

You may submit additional information or documentation to support your request for the health care services.

Preliminary Review
Within 5 business days of receipt of your request, Blue Cross and Blue Shield of Illinois will complete a **preliminary review** of your request to determine whether:

- You were 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
- You have exhausted Blue Cross and Blue Shield of Illinois's internal grievance process (in certain urgent cases, you may be eligible for expedited external review even if you has not filed an internal appeal with Blue Cross and Blue Shield of Illinois, and you may also be eligible for external review if you 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 you have filed a request for an expedited internal appeal)
- You have provided all the information and forms required to process an external review

For external reviews relating to a determination based on treatment being **experimental/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/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 your condition
- Standard health care services or treatments are not medically appropriate for you
- 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 you, in the opinion of your health care **provider**, than any available standard health care services or treatments
- That scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you 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 you and your 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, you 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 may be 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 your **benefit** program and shall be subject to all **applicable laws** or regulatory guidance, as appropriate.

Assignment of IRO
If your 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 you and your 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, you or your 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, you and, if applicable, your authorized representative, of its decision to reverse the determination.

If you or your 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 you or your 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, you, and if applicable, your 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 you, or if applicable, your authorized representative, the IRO shall also consider the following information if available and appropriate:

- Your medical records
- Your 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/investigational**, whether and to what extent (1) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, (2) 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 (3) the terms of coverage under your **benefit** program to ensure that the health care services or treatment would otherwise be covered under the terms of coverage of your **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. You and your 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
- 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/investigational** treatments, the notice shall include the following additional information:

- A description of your 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 you 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 you 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 you have a medical condition where the timeframe for completion of an expedited internal review of a grievance involving an **adverse determination**, a **final adverse determination** as set forth in the Illinois Managed Care Reform and Patient Rights Act, or a standard external review as set forth in the Illinois Health Care External Review Act, would seriously jeopardize your life or health or your ability to regain maximum function, then you have 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 you received **emergency services**, but have not been discharged from a facility, then you may request an **expedited external review**.

You 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/investigational** and your health care **provider** certifies in writing that the treatment or service would be significantly less effective if not started promptly.

Your 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 you and your 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 your 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 you and your 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, you or your 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, you and, if applicable, your 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 you 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 you, Blue Cross and Blue Shield of Illinois and, if applicable, your 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 you, except to the extent you have other remedies available under applicable federal or state law. You and your authorized representative may not file a subsequent request for external review involving the same **adverse determination** or **final adverse determination** for which you have 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 you access 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, you will receive it from one of two kinds of **providers**. Most **providers** ("**participating providers**") contract with the local Blue Cross and/or Blue Shield Licensee in that 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 you receive **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 **prior authorization**. If **prior authorization** is not obtained, the **participating provider** will be sanctioned based on the **Host Blue's** contractual agreement with the **provider**, and the member will be held harmless for the **provider** sanction.

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

- The billed **covered charges** for your **covered services**
- The negotiated price that the **Host Blue** makes available to the **plan**

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

Suppose you receive **covered services** for an illness while you are on vacation outside of Illinois. You show your **identification card** to the provider to let them know that you are 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 you must pay for the service - the amount applied to your **deductible**, if any, and your **coinsurance** percentage - on the $80 negotiated price, not the $100 billed charge. So, for example, if your **coinsurance** is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a **covered service**.

PLEASE NOTE: The Coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), copayment(s), and coinsurance 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 your **provider**. Sometimes, it is an estimated price that takes into account special arrangements with your **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 your **claim** because they will not be applied after a **claim** has already been 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 you pay for such services will be calculated using the methodology described in this policy for **non-participating providers** located inside our service area. You may be responsible for the difference between the amount that the **non-participating provider** bills and the payment the **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 this **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 prior authorization 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, you have 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 you 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, your **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 you. 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 you attempt 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.

You retain 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 you or your covered **dependent** incur expenses for **sickness** or **injury** that occurred due to the negligence of a third-party and **benefits** are provided for **covered services** described in this **policy**, you 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 you, your parents if you are a minor, or your 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 you, reduced by any **average discount percentage** (ADP) applicable to your **claim** or **claims**.
- We are assigned the right to recover from the third-party, or their 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 you, your parents if you are a minor, or your 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**.

You are 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 this **policy** change
- A division, subsidiary, affiliated organization, or eligible class is added or deleted from this **policy**
- 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.

Unpaid Premium
Upon the payment of a **claim** under this **policy**, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

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 this **policy** will continue in force provided that the policyholder 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 policyholder is in default of the their 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 policyholder (including any and all contractual obligations of us to the policyholder) may be offset and/or recouped and applied toward the payment of the policyholder's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due the policyholder.

If the policyholder 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 policyholder 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 this **policy**. For purposes of this section mere receipt and/or negotiation of a late premium payment does not constitute acceptance. Any reinstatement of this **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 this **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 you
- Accept the **allowable amount** determination as payment for **medically necessary** services and not bill you for services over the **allowable amount** determination. **Benefits** will be subject to the out-of-network:
  - **Deductible**, **copayment(s)**, **coinsurance**
  - Limitations and exclusions
  - Maximums

GENERAL PROVISIONS

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 you 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 this **policy**, unless it is contained in a written application. No change in this **policy** shall be valid until approved by an executive officer of ours and unless such approval is endorsed hereon or attached hereto. The issuance of this **policy** supersedes all previous contracts or **policies** between us and the policyholder which are in force on the effective date of this **policy**.

No agent has the authority to modify or waive any part of this **policy**, or to extend the time for payment of premiums, or to waive any of our rights or requirements. No modifications of this **policy** will be valid unless evidenced by an endorsement or amendment of this **policy**, signed by one of our 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 (1) the person to, or for whom, such **benefits** were paid, (2) any insurance company or plan, or (3) 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:

- Any future **benefit** payment owed to any person or entity under this **policy**, whether for the same or a different member
- 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**
- 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**
- Any future **benefit** payment, or other payment, made to any person or entity
- 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

This **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 this **policy**
- 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.

Renewability

This policy shall be renewed or continued in force at your option except for:

- Nonpayment of premium
- Fraud
- Termination of the plan
- Movement outside the service area
- Association membership ceases

Premium Rebates, 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 **deductibles**, **copayments**, and/or **coinsurance** 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 this **policy** and within 2 years after final termination of this **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 this **policy** prior to the expiration of 60 days after a **claim** has been furnished to us in accordance with the requirements of this **policy**. No such action shall be brought after the expiration of 3 years after the time a **claim** is required to be furnished to us. No extension of the time granted under this **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 this **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 your commission of or attempt to commit a felony or to which a contributing cause was you 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 you 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 this **policy**, if any, the maximum amount of **benefits** payable by the plan and all required **deductible**, **copayment**, 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 you 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 you under this **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 you under this **policy**.

The policyholder understands that we may receive such discounts during the term of this **policy**. Neither the policyholder nor you 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 you 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 you, under this **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 this **policy**. Neither the policyholder nor you 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 this **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 to 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:

- Use the information only for the purpose of complying with the terms and conditions of its contract with the policyholder
- 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
- Advise its employees who receive the information of the existence and terms of these provisions and of the obligations of confidentiality herein
- 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
- Not duplicate the information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of this **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 this **policy**.

Identity Theft Protection Services

Blue Cross and Blue Shield of Illinois makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by a Blue Cross and Blue Shield of Illinois designated outside vendor and acceptance or declination of these services is optional to you. If you 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 your **identification card** or by visiting the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com. Services may automatically end when you are 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 this **policy**. Further, for purposes of determining the number of votes to which the policyholder may be entitled, any reference in this **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 you and the policyholder, the policyholder hereby expressly acknowledges its understanding that this **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 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 this **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 our obligations to the policyholder created under this **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 your coverage (and/or your **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 your application, or any practice that constitutes fraud may result in a **rescission** of your coverage (and/or your **dependent(s)** coverage) retroactive to the effective date, subject to prior notification. You have 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.