POLICYHOLDER:	Rush University
POLICY NUMBER:	115703 (“the Policy”)
EFFECTIVE DATE:	August 1, 2017
POLICY TERM:	August 1, 2017 through July 31, 2018
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. The Policy is issued in the state of Illinois and is governed by its laws. The Policy becomes effective at 12:00 A.M. on the Policy Effective Date at the Policyholders address.

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

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

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

Jeffrey R. Tikkanen
President of Retail Markets
Blue Cross and Blue Shield of Illinois
300 E. Randolph St.
Chicago, IL 60601

BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE
PLEASE READ THIS POLICY CAREFULLY

STU2010-IL

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

NOTICE

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

Please refer to the provision entitled "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

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

Please refer to the provision entitled "Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

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

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

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

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SCHEDULE OF BENEFITS

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

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

CLASSES OF ELIGIBLE PERSONS:

Class I: Rush University Policy requires all Rush Medical College, College of Health Sciences, College of Nursing and Graduate College students have quality health insurance. Enrollment in the plan for all College of Health Sciences, College of Nursing and Graduate College students is required unless the student provides proof of coverage under a comparable plan.

A person may be insured only under one class of eligible persons even though he or she may be eligible under more than one class.

Dependents, as defined by this Policy, of all Insureds are eligible for coverage under this Policy.

Students must actively attend classes for at least the first 31 consecutive days after the date for which coverage is purchased.

A person may not be insured as a Dependent and an Insured at the same time.

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

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

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

Deductible:	**Network Provider**	**Out-of-Network Provider**
Per Covered Person per Benefit Period:	$250	$500
Per Family per Benefit Period	$500	$1,500

If a Student has Family Coverage, each member of his/her family must satisfy the Deductible. If a Student's family has satisfied the family Deductible amount of $500 for Covered Expenses rendered by

Network Provider(s) and a separate $1,500 family Deductible for Covered Expenses rendered by Out-of-Network Provider(s) or Non-Plan Provider(s), it will not be necessary for anyone else in a Student's family to meet the Deductible in that Benefit Period. That is, for the remainder of that Benefit Period only, no other family members(s) will be required to meet the Deductible before receiving benefits.

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

Once the Out-of-Pocket Maximum has been satisfied, Covered Expenses will be payable at 100% for the remainder of the Benefit Period up to any maximum that may apply.

Out-of-Pocket Maximum:	**Network Provider**	**Out-of-Network Provider**
Per Covered Person per Benefit Period:	$6,350	$15,000
Per Family per Benefit Period	$12,700	$25,400

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

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

The following expenses cannot be applied to the Network Out-of-Pocket Maximum and will not be paid at 100% of the Allowable Amount when a Covered Person's 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 or a Non-Plan Provider
- penalty amounts for failing to follow Preauthorization requirements
- services, supplies, or charges limited or excluded in this Policy
- expenses not covered because a benefit maximum has been reached

- any Covered Expenses paid by the Primary Plan when BCBSIL is the secondary plan for purposes of coordination of benefits

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

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

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

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

If a Student has Family Coverage, each member of his/her family must satisfy the Out-of-Pocket Maximum. If a Student's family has satisfied the family Out-of-Pocket Maximum of $12,700 for Covered Expenses rendered by Network Provider(s) and a separate $25,400 family Out-of-Pocket Maximum for Covered Expenses rendered by Out-of-Network Provider(s), it will not be necessary for anyone else in a Student's family to meet the Out-of-Pocket Maximum in that Benefit Period. That is, for the remainder of that Benefit Period only, no other family member(s) will be required to meet the Out-of-Pocket Maximum before Covered Expenses (except for those expenses specifically excluded above) will be payable at 100%.

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

PREAUTHORIZATION REQUIREMENTS

IMPORTANT: BCBSIL should be notified of all Hospital Confinements prior to admission in order to avoid a penalty for that care, except as noted below. Failure to follow the notification procedures will not affect benefits otherwise payable under the Policy; however, Preauthorization notification is not a guarantee that benefits will be paid. Actual availability of benefits is subject to eligibility and other terms, conditions, limitations, and exclusions of this Policy, if any.

1. **Preauthorization Notification of Medical Non-Emergency Hospitalizations:** The patient, Doctor or Hospital should telephone 1-800-635-1928 at least 1 business day prior to the planned admission.
2. **Preauthorization Notification of Medical Emergency Hospitalizations:** The patient, patient's representative, Doctor or Hospital should telephone 1-800-635-1928 within 2 business days of the admission or as soon as reasonably possible to provide the notification of any admission due to medical emergency.

BCBSIL is open for Preauthorization notification calls from 8:00 a.m. to 6:00 p.m., C.S.T., Monday through Friday. Calls may be left on the customer service department's voice mail after hours by calling 1-800-635-1928 for Medical or 1-800-851-7498 for Mental Health.

Preauthorization Required	Out-of-Network Penalty Amount
Inpatient Admission	$250
Inpatient Admission – Mental Illness	$250
Inpatient Admission – Serious Mental Illness	$250
Inpatient Admission – Substance Use Disorder	$250

NOTE: BCBSIL must receive Preauthorization notifications for all Hospital Confinements, regardless of a penalty amount mentioned above in order to receive maximum benefits under this Policy. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

RADIOLOGY QUALITY INITIATIVE (RQI) PROGRAM

An RQI number is required by BCBSIL prior to performing any of the high-tech, elective, non-emergency diagnostic imaging services listed below for Covered Persons:

- CT and CTA scans
- MRI and MRA scans
- Nuclear Cardiology studies

- PET scans

The RQI program applies to all of the above imaging services when performed in a Physician's office, the outpatient department of a Hospital or a freestanding imaging center. Ordering Physicians can obtain, and imaging service Providers can confirm, a Covered Person's RQI number via American Imaging Management's (AIM's) website at *www.aimspecialtyhealth.com*. Additional information about AIM and the RQI process is available in the Claims and Eligibility/Prior Authorization/High-tech Imaging Services section of Our website at *www.bcbsil.com/provider*.

Note: If an RQI number cannot be issued, a Covered Person will be directed back to BCBSIL to complete the predetermination process. The RQI program is not a substitute for the pre-certification process.

BENEFIT HIGHLIGHTS

Covered Persons' benefits are highlighted below. However, to fully understand their benefits, it is very important that Covered Persons read this entire Policy. The program below is designed to provide Covered Persons with economic incentives for using designated Providers of health care services. Although Covered Persons can go to the Hospital or Professional Provider of their choice, benefits under the Policy will be greater when they use the services of a Network Provider.

Covered Expenses	**Network Provider Covered Person Pays**	**Out-of-Network Provider* Covered Person Pays**
Inpatient Expenses		
Hospital Expenses	20% of Allowable Amount	50% of Allowable Amount
Surgical Expenses for a primary procedure -Remaining eligible procedure	20% of Allowable Amount 50% of Allowable Amount	50% of Allowable Amount 50% of Allowable Amount
Assistant Surgeon Services	20% of Allowable Amount	50% of Allowable Amount
Anesthetist Services	20% of Allowable Amount	50% of Allowable Amount
Doctor's Visits	20% of Allowable Amount	50% of Allowable Amount
Outpatient Expenses		
Surgical Expenses for a primary procedure -Remaining eligible procedures	20% of Allowable Amount 50% of Allowable Amount	50% of Allowable Amount 50% of Allowable Amount
Day Surgery/Outpatient Surgical Expenses	20% of Allowable Amount	50% of Allowable Amount
Day Surgery Miscellaneous Services	20% of Allowable Amount	50% of Allowable Amount

Assistant Surgeon Services	20% of Allowable Amount	50% of Allowable Amount
Anesthetist Services	20% of Allowable Amount	50% of Allowable Amount
Outpatient Doctor's Visits -non-specialist subject to a $20 Copayment -specialist subject to a $40 Copayment	No Charge	50% of Allowable Amount
Physical, Occupational and Speech Therapy Services	20% of Allowable Amount	50% of Allowable Amount
Emergency Room/Treatment Room Accidents and Emergency Care (including Accidents and Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures) subject to a $250 Copayment per visit (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	20% of Allowable Amount, no Deductible	20% of Allowable Amount, no Deductible
- Physician charges	20% of Allowable Amount	20% of Allowable Amount
- Diagnostic X-ray and Laboratory Services	20% of Allowable Amount	20% of Allowable Amount

Non-Emergency Care (including Non-Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures) subject to a $250 Copayment per visit (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment) subject to a $500 Copayment per visit for Out-of-Network Providers (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	20% of Allowable Amount, no Deductible	50% of Allowable Amount
- Physician charges	20% of Allowable Amount	50% of Allowable Amount
- Lab and x-ray charges	20% of Allowable Amount	50% of Allowable Amount
Urgent Care subject to a $50 Copayment	20% of Allowable Amount, no Deductible	50% of Allowable Amount
Radiation & Chemotherapy Services	20% of Allowable Amount	50% of Allowable Amount
Allergy Injections and Allergy Testing	20% of Allowable Amount	50% of Allowable Amount
Chiropractic and Osteopathic Manipulation Benefits will be limited to 25 visits per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Other Expenses		
Additional Surgical Opinion	20% of Allowable Amount	50% of Allowable Amount
Cardiac Rehabilitation Services Benefits will be limited to 36 visits per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Durable Medical Equipment	20% of Allowable Amount	50% 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	50% of Allowable Amount

Ambulance Transportation**	20% of Allowable Amount	20% of Allowable Amount
Routine Well-Baby Care	20% of Allowable Amount	50% of Allowable Amount
Dental Treatment (Injury only to sound, natural teeth)	20% of Allowable Amount	20% of Allowable Amount
Tests and Procedures	20% of Allowable Amount	50% of Allowable Amount
Skilled Nursing Facility	20% of Allowable Amount	50% of Allowable Amount
Coordinated Home Health Care	20% of Allowable Amount	50% of Allowable Amount
Hospice Services	20% of Allowable Amount	50% of Allowable Amount
Mental Illness and Substance Use Disorder Services	20% of Allowable Amount	50% of Allowable Amount
Autism Spectrum Disorder(s)	20% of Allowable Amount	50% of Allowable Amount
Habilitative Services	20% of Allowable Amount	50% of Allowable Amount
Blood and Blood Components	20% of Allowable Amount	50% of Allowable Amount
Private Duty Nursing Services	20% of Allowable Amount	50% of Allowable Amount
Naprapathic Services Benefits will be limited to 15 visits per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Bariatric Surgery	20% of Allowable Amount	50% of Allowable Amount
Routine Pediatric Hearing Examinations	20% of Allowable Amount	50% of Allowable Amount
Pulmonary Rehabilitation Therapy	20% of Allowable Amount	50% of Allowable Amount
Massage Therapy	20% of Allowable Amount	50% of Allowable Amount
Virtual Visits subject to a $20 Copayment	No Charge	NA
Organ and Tissue Transplants	20% of Allowable Amount	40% of Allowable Amount

Needle Stick, only for Students doing course work or Hospital training	No Charge	No Charge
Voluntary Termination of Pregnancy	20% of Allowable Amount	50% of Allowable Amount
Preventive Care Services	No Charge	50% of Allowable Amount

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

* Covered Persons will be responsible for the difference between the Allowable Amount and the billed charges, when receiving Covered Services from an Out-of-Network Provider. Non-Plan Provider benefits will be paid by the Insurer at 50% of the Allowable Amount. Covered Persons will pay 50% of the Allowable Amount plus the difference between the Allowable Amount and the billed charges when receiving Covered Services from a Non-Plan Provider. The Average Discount Percentage (as defined below in the "Definitions" section) does not apply to Non-Plan Providers.

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

TO IDENTIFY NON-PLAN AND PLAN HOSPITALS OR FACILITIES, COVERED PERSONS SHOULD CONTACT BLUE CROSS AND BLUE SHIELD CUSTOMER SERVICE AT 1-855-267-0214.

Outpatient Prescription Drug Program

Copayments for Outpatient Prescription Drugs*:	**Network Provider Pharmacy Covered Person Pays**
Generic Drugs and generic diabetic supplies and insulin and insulin syringes	$20 per prescription
Preferred Brand Name Drugs and preferred brand name diabetic supplies and insulin and insulin syringes	$50 per prescription
Non-Preferred Brand Name Drugs and non-preferred brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available	$80 per prescription, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription

* One prescription means up to a 30 consecutive day supply of a drug (except for certain drugs). Covered Persons can purchase a 90 day supply for 3 times the retail amount.

Covered Persons will be responsible for the difference between the Allowable Amount and the billed charges, when receiving Prescription Drugs from an Out-of-Network Pharmacy.

DEFINITIONS

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

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

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

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

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

For a Provider other than a Professional Provider which does not have a written agreement with Us or another Blue Cross and/or Blue Shield Plan to provide care to the Covered Person at the time Covered Expenses are incurred, the Allowable Amount will be the lesser of:

i. the Provider's billed charges, or;

ii. 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.

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.

We will utilize the same Claim processing rules and/or edits that We utilize in processing 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 Network Provider and Out-of-Network Provider Pharmacies - The Allowable Amount for pharmacies that are Network 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 not Network Providers will be based on the Average Wholesale Price.

"Ambulance Transportation" means local transportation in specially equipped certified ground and air transportation options from a Covered Person's home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to a Covered Person's home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

"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:

i. A federally funded or approved trial,
ii. A clinical trial conducted under an FDA investigational new drug application, or
iii. A drug that is exempt from the requirement of an FDA investigational new drug application.

"Average Discount Percentage ("ADP")" means a percentage discount determined by Us that will be applied to an Allowable Amount for Covered Expenses rendered to the Covered Person by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, Deductibles, Out-of-Pocket Maximums and/or benefit maximums. The ADP applicable to a particular Claim for Covered Expenses is the ADP, current on the date the Covered Expense is incurred, which is determined by Us to be relevant to the particular Claim. The ADP reflects Our reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect such costs. (See provisions of this Policy regarding "Our Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular

Claim, We will take into account differences among Hospitals and other facilities, the nature of the Covered Expenses involved and other relevant factors. The ADP shall not apply to Allowable Amounts when the Covered Person's benefits under this Policy are secondary to Medicare and/or coverage under any other group program.

"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 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.

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

"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 the Policy. The Benefit Period is as agreed to by the Policyholder and the Insurer.

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

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

"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 Us that a service has been rendered or furnished to the Covered Person. This notification must include full details of the service received, including the Covered Person's name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of the service, the diagnosis, the Claim Charge, and any other information which We may request in connection with services rendered to the Covered Person.

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

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

Provider. (See provisions of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

"Clinical Social Worker" means a duly licensed Clinical Social Worker.

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

"Company" 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 "BCBSIL").

"Complications of Pregnancy" means:

- Conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning Sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and
- Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

"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.

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

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

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

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

"Covered Service" means a service or supply specified in this Policy for which benefits will be provided.

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

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

"Dependent" means:

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

Coverage will continue for a child who is 26 or more years old, chiefly supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap. 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 Service" means tests rendered for the diagnosis of a Covered Person's symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

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

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

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

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

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

"Drug List" means a list of drugs that may be provided under the Outpatient Prescription Drug Program section of this Policy. The Drug List and any modifications are available on Our website at *www.bcbsil.com*. Covered Persons may also contact a Customer Service representative at 1-855-267-0214 for more information.

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

"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, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, Sickness, or Injury is of such a nature that failure to get immediate care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment of bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

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

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

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

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

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

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

"Generic Drug" means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Prescription Drugs and corresponding payment level, Blue Cross and Blue Shield utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information. A list of Generic Drugs is available by accessing the website at *www.bcbsil.com*. A Covered Person may also contact a Customer Service at 1-855-267-0214 for more information.

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

"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; and

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

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

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

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

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

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

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

"Interscholastic Activities" means playing, participating and/or traveling to or from an interscholastic, intercollegiate, club sports, professional, or 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 Care Services" means those social services, personal care services and/or Custodial Care Services needed by a Covered Person when he/she have lost some capacity for self-care because of a chronic illness, Injury or condition.

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

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

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

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

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

"Naprapath" means a duly licensed Naprapath.

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

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

"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. This Drug List is available by accessing the website at *www.bcbsil.com.*

"Occupational Therapist" means a duly licensed Occupational Therapist.

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

"Optometrist" means a duly licensed Optometrist.

"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 a Network Provider to the Covered Person at the time services are rendered. The term "Out-of-Network Provider" includes both Plan Providers and Non-Plan Providers, but does not include Network Providers. For questions concerning Out-of-Network Providers, please call Blue Cross and Blue Shield of Illinois Customer Service at 1-855-267-0214.

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

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

"Pharmacy" means a state and federally licensed establishment where the practice of Pharmacy occurs, that is physically separate and apart from any Provider's office, and where legend drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

"Physical Therapist" means a duly licensed Physical Therapist.

"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 to the Institution, any addenda, the Institution's Application for Student Blanket Health Insurance, the Covered Person's application(s) for coverage, as appropriate, along with any exhibits, appendices, addenda and/or other required information.

"Preauthorization" means the process that determines in advance the Medical Necessity or Experimental/Investigational nature of certain care and services under this Policy.

"Preferred Brand Name Drug" means a brand name Prescription Drug product that is identified as a Preferred Brand Name Drug on the applicable Drug List and is subject to the Preferred Brand Name Drug Copayment. This list is available by accessing the website at *www.bcbsil.com.*

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

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

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

"Private Duty Nursing Service" means services received in a Skilled Nursing Facility 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.

"Professional Provider" means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider designated by Us (or other participating Blue Cross and/or Blue Shield Plan).

"Provider" means any health care facility or person or entity duly licensed to provide the Covered Person with treatment, services and supplies not excluded or limited by the Policy.

a) **"Plan Provider"** means a Provider which has a written agreement with Us (or another Blue Cross and/or Blue Shield Plan) to provide services to the Covered Person at the time services are rendered to the Covered Person.
b) **"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. Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois "Psychologists Registration Act" or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

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

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

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a Psychologist with at least two years of supervised experience in health services.

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

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

"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" has the meaning set forth in the RESCISSION OF COVERAGE provision of this Policy.

"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. Requirements: 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 Costs" 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:

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

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

"Specialty Drugs" means Prescription Drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, a Covered Person should contact his/her Pharmacy, refer to the *Drug List* by accessing the website at *www.bcbsil.com* or contact Customer Service at 1-855-267-0214.

"Specialty Pharmacy Provider" means a Participating Prescription Drug Provider that has a written agreement with Blue Cross and Blue Shield of Illinois or the entity chosen by Blue Cross and Blue Shield of Illinois to administer its Prescription Drug program to provide Specialty Drugs to Covered Persons.

"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.

"Student(s)" means an individual Student or continued person who meets the eligibility requirements for this health coverage, as described in the eligibility requirements of this Policy.

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

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

"Substance Use Disorder Rehabilitation Treatment" means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. 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 retardation 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.

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

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

"Virtual Visit" means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the Virtual Visits provision under the Accident and Sickness Medical Expense Benefits section of this Policy.

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

ELIGIBILITY FOR INSURANCE

Each person in the Class(es) of Eligible Persons shown in the Schedule of Benefits 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 the Policy is in force. Students must actively attend class for the number of days as listed on the Schedule of Benefits. We maintain the right to investigate Student status and attendance records to verify that eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any premium paid for that person.

A person may be insured under only one class of Eligible Persons shown in the Schedule of Benefits, even though the person may be eligible under more than one Class.

An Insured's Dependent is eligible on the date:

- the Insured is eligible, if the Insured has Dependents on that date; or
- the date the person becomes a Dependent of the Insured, if later.

In no event will a Dependent be eligible if the Insured is not enrolled for coverage under this Policy.

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, 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, sex, gender identity, marital status or sexual orientation. 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.

ELIGIBILITY FOR CHILD-ONLY COVERAGE

Eligible children that have not attained age 21 may enroll as the enrollee under this health care plan. In such event, this health care plan is considered child-only coverage and the following restrictions apply:

- The parent or legal guardian is not covered and is not eligible for benefits under this health care plan.
- **If a child covered under this plan acquires a new eligible child of his/her own, the new eligible child may be enrolled in his/her own plan coverage if application for coverage is made within 30 days.**
- If a child in under the age of 18, his/her parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and/or other required information to the Plan, as appropriate. For any child under 18 covered under this health care plan, any obligations set forth in this Plan, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Application for child only coverage will not be accepted for an adult child that has attained age 21 as of the beginning of the plan year. Adult children (at least 18 years of age but have not attained age 21) who are applying as the enrollee under this plan must apply for their own individual plan and must sign or authorize the application(s).

EFFECTIVE DATE OF INSURANCE

Insurance for an Eligible Person who enrolls during the program's enrollment period, as established by the school, is effective on the latest of the following dates:

- the Policy Effective Date;
- the date We receive the completed enrollment form;
- the date after the required premium is paid; or
- the date the Student enters the Eligible Class.

Coverage for a Student's eligible Dependent who enrolls:

- during the enrollment period established by the Policyholder; or
- within 31 days after the Student acquires a new Dependent; or
- 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 Coverage Period;
- the date the Student enters the Eligible Class;
- the date We receive the completed enrollment form; and
- the date after the required premium is paid.

After the time periods described above, the Student or 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 until that child is 31 days old. Coverage may be continued beyond the 31 days if the Covered Person notifies Us of the child's birth and pays the required premium, if any.

Adopted children, as defined by the 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 Plan Administrator along with the Institution will designate open enrollment periods during which Students may apply for or change coverage for himself/herself and/or his/her eligible spouse and/or Dependents.

This section "Open Enrollment Periods" is subject to change by Blue Cross and Blue Shield, and/or applicable law, as appropriate.

QUALIFYING EVENT

Eligible Students and eligible Dependents who have a change in status and lose coverage under another Health Care Plan are eligible to enroll for coverage under the Policy provided, within 31 days of the qualifying event, such Students must send to Academic HealthPlans with a completed qualifying events form and the letter of ineligibility. 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, or loss of Dependent status because of age. The premium will be 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 the Student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends.

DISCONTINUANCE OF INSURANCE

TERMINATION DATE OF INSURANCE

An Insured's coverage will end on the earliest of the date:

- the Policy terminates;
- the Insured is no longer eligible;
- the period ends for which premium is paid.

A Dependent's coverage will end on the earliest of the date:

- he or she is no longer a Dependent;
- the Insured's coverage ends; or
- the period ends for which premium is paid; or
- the Policy terminates.

REFUND OF PREMIUM

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

- of a Covered Person's death; or
- the Covered Person enters full-time active duty in any Armed Forces; and
- We receive proof of such active duty service.

EXTENSION OF BENEFITS

If a Covered Person is confined in a Hospital for a medical condition on the date his or her 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:

- the Covered Person's medical condition no longer continues;
- the Covered Person reaches any maximum that may apply; or
- the Covered Person obtains 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 the Policy may continue to be insured under the Policy when coverage terminates subject to the following:

- Continuation of Coverage is available to Insureds and their covered Dependents, when the Insured 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 the Policy for at least 3 months.
- Requests for Continuation of Coverage, with the applicable premium, must be mailed to the Plan Administrator, within 31 days of:
  - the date the existing coverage would otherwise terminate; or
  - the date the Covered Person is notified by the Plan Administrator 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 in the Student Insurance Office.
- The maximum period for which coverage may be continued is 3 months.
- Continuation of Coverage is not available to persons who are eligible for coverage under another Health Care Plan, including Medicare.

STUDENT EXTENSION

Coverage provided under the Policy for a Covered Dependent who is a full-time Student will not terminate due to a Medically Necessary leave of absence from school which causes a loss of full-time Student status.

Documentation and certification of the Medical Necessity of the leave of absence must be submitted to the Insurer by the Student's Doctor.

Any breaks in the school semester/term shall not disqualify the Covered Dependent from coverage.

Coverage will be continued until the first of the following occurs:

- One year (12 months) has elapsed from the date the continuation due to the medical leave of absence began and the covered Dependent student has not returned to school on a full-time basis;
- The Student advises the Insurer that he or she does not intend to return to school on a full-time basis;
- The Student becomes employed on a full-time basis;
- The Student obtains other health insurance;
- The Student marries or enters into a Civil Union and is eligible for health care under the spouse's or party to a Civil Union's health care plan;
- The Student reaches the Dependent maximum age at which coverage would otherwise terminate under the terms and conditions of the group health Policy; or
- The Policy is terminated or not renewed.

BENEFIT DESCRIPTION

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

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

Covered Expenses include:

Inpatient Expenses

- Hospital Expenses:
  - daily room and board at a semi-private room rate when Hospital Confined;
  - general nursing care provided and charged for by the Hospital;
  - intensive care. We will make this payment in lieu of the semi-private room expenses;
  - coordinated home care benefits following Hospital Confinement;
  - Hospital Miscellaneous Expenses: expenses incurred while Hospital Confined or as a precondition for being Hospital Confined, for services and supplies such as the cost of operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, Physical Therapy, therapeutic services and supplies. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
- Surgical Expense: Surgeon's fees for Inpatient Surgery paid as shown in the Benefit Highlights. If an Injury or Sickness requires multiple surgical procedures, We will cover according to the Allowable Amount shown in the Benefit Highlights.
- Preadmission Testing: when Medically Necessary, in connection with Inpatient Surgery.
- Assistant Surgeon Services: when Medically Necessary, in connection with Inpatient Surgery.
- Anesthetist Services: in connection with Inpatient Surgery.
- Doctor's Visits: when Hospital Confined. Benefits do not apply when related to Surgery and will be paid as a Covered Inpatient Expense as shown in the Benefit Highlights.
- Staff nursing care while confined to a Hospital by a licensed registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN).
- Routine Costs for Participants in Approved Clinical Trials: Benefits will be provided for Routine Patient Costs in connection with a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.
- Rehabilitative Services

Outpatient Expenses

- Day Surgery/Outpatient Surgical Expense: Surgeon's fees for Outpatient Surgery paid as shown in the Benefit Highlights. If an Injury or Sickness requires multiple surgical procedures, We will cover according to the Allowable Amount shown in the Benefit Highlights.
- Day Surgery Miscellaneous Expenses: Services related to scheduled Surgery performed in a Hospital or ambulatory surgical center, including operating room expenses, laboratory tests and diagnostic test expense, examinations, including professional fees, anesthesia; drugs or medicines; therapeutic services and supplies. Benefits will not be paid for: Surgery performed in a Hospital emergency room, Doctor's office, or clinic. Benefits for oral Surgery are limited to the following services:
  - surgical removal of complete bony impacted teeth;
  - excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.
- Preadmission Testing: when Medically Necessary, in connection with Outpatient Surgery.
- Assistant Surgeon Services: when Medically Necessary, in connection with Outpatient Surgery.
- Anesthetist Services: in connection with Outpatient Surgery.
  - Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon's office, Hospital or Ambulatory Surgical Facility if you are under age 19 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.....a pervasive developmental disorder described by the American Psychiatric Association or the World Health Organization diagnostic manuals as an autistic disorder, atypical autism, Asperger Syndrome, Rett Syndrome, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified; or a special education classification for autism or other disabilities related to autism.

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

    - It is attributable to cerebral palsy, epilepsy or any other condition, other than a Mental Illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and

requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;

- It manifested before the age of 22;
- It is likely to continue indefinitely; and
- It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.

- Doctor's Visits: Benefits will be paid as shown in the Benefit Highlights. Doctor visits related to Surgery or Physical, Occupational or Speech Therapy or Chiropractic and Osteopathic Manipulation or Diagnostic Services, CT scans, PET scans or MRIs will not be subject to a Copayment, and benefits will be paid as a Covered Outpatient Expense as shown in the Benefit Highlights.
- Physical, Occupational and Speech Therapy Expenses.
- Diagnostic X-ray and Laboratory Services: when Medically Necessary and performed by a Doctor will include Diagnostic Services and medical procedures performed by a Doctor, other than Doctor's visits, X-ray and lab procedures.
- Medical Emergency Expenses: only in connection with Emergency Care as defined. Benefits will be paid as shown in the Benefit Highlights for the use of the emergency room and supplies. However, Covered Services received for Medical Emergency Expenses resulting from criminal sexual assault or abuse will be paid at 100% of the Allowable Amount whether or not a Covered Person has met their Deductible. The emergency room Copayment will not apply.
- Urgent Care
- Radiation & Chemotherapy
- Electroconvulsive Therapy
- Renal Dialysis Treatments: If received in a Hospital, a Dialysis Facility or in a Covered Person's home under the supervision of a Hospital or Dialysis Facility.
- Allergy Injections and Allergy Testing
- Chiropractic and Osteopathic Manipulation: Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 25 visits per Benefit Period.
- Diabetes Self-Management Training and Education: Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits for such health care professionals will be paid as an Other Covered Expense as shown in the Benefit Highlights. Benefits for Physicians will be paid as a Covered Outpatient Expense as shown in the Benefit Highlights.

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

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

Other Expenses

- Additional Surgical Opinion: A Covered Person's coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. A Covered Person's benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge. A Covered Person's Deductible will not apply to this benefit. If a Covered Person requests, benefits will be provided for an additional consultation when the need for Surgery, in his/her opinion, is not resolved by the first arranged consultation.
- Cardiac Rehabilitation Services: A Covered Person's benefits for cardiac rehabilitation services are the same as his/her benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits are available if a Covered Person has a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.
- Durable Medical Equipment, Prosthetics, Braces and Appliances, and medical services: for Medically Necessary services: 1) when prescribed by a Doctor; and 2) a written prescription accompanies the claim when submitted. Replacement or repairs to braces and appliances are not covered. Durable, medical equipment is equipment that:
  - is primarily and customarily used to serve a medical purpose;
  - can withstand repeated use; and
  - generally is not useful to person in the absence of Injury.

  No benefits will be paid for rental charges in excess of the purchase price.
- 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 neckbraces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in the Covered Person's physical condition, as Medically Necessary. Benefits for foot orthotics will be limited to two orthotic devices or one pair of foot orthotic devices per Benefit Period.
- Ambulance Service. Payment will be made to the Provider as shown in the Benefit Highlights. Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation. When receiving benefits for Ambulance Transportation related to Emergency Care, Covered Persons will not be responsible for amounts other than those listed in the Benefit Highlights of this Policy.
- Consultant Doctor Fees: when requested and approved by the attending Doctor.

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

- In-vitro Fertilization Expenses: Benefits will be paid for Outpatient expenses only when:
  - A Covered Person has been unable to attain a viable pregnancy, maintain a viable pregnancy, or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if a Student or his/her partner has a medical condition that makes such treatment useless. Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per Benefit Period.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to a Covered Person. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and Prescription Drugs.

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

Special Limitations for the Diagnosis and Treatment of Infertility:

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from a Covered Person will be covered if he/she chooses to use a surrogate.

2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of a Covered Person's home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to a Student's Dependents under age 18.

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

- 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.
- The Insurer will pay the actual expenses incurred, including Medically Necessary maternity testing, as a result of pregnancy, childbirth, miscarriage, or any Complications of Pregnancy resulting from any of these. Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:
  - a minimum of 48 hours of Inpatient care following a vaginal delivery; or
  - a minimum of 96 hours of Inpatient care following delivery by cesarean section.

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

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

- Parental education;
- Assistance and training in breast or bottle feeding; and
- 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: 1) while the baby is Hospital Confined; and 2) for routine nursery care provided within the first 31 days after birth, including treatment of diagnosed congenital and birth abnormalities.
- Dental Treatment (Injury Only): when performed by a Doctor and made necessary by Injury to sound, natural teeth. If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted dental standards of the American Dental Association.
- Tests and Procedures: Diagnostic Services and medical procedures performed by a Doctor, other than Doctor's Visits, Physical Therapy and X-rays and Lab procedures.
- Skilled Nursing Facility: Covered Inpatient Hospital Services and supplies given to an Inpatient of an eligible Skilled Nursing Facility. Subject to the Preauthorization guidelines set forth in this Policy. No benefits are payable:
  - Once the Covered Person can no longer improve from treatment; or
  - For Custodial Care, or care for someone's convenience.

  No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.
- Coordinated Home Health Care: Includes the following Covered Services the Covered Person receives from a Hospital program for Coordinated Home Health Care, provided such program is an eligible Provider and the care is prescribed by a Physician:
  - Medical and surgical supplies;
  - Prescribed Drugs;
  - Oxygen and its administration;

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

  Coordinated Home Health Care is subject to the Preauthorization guidelines set forth in this Policy. No benefits are payable for:
  - Dietician service, except as specified for diabetes self-management training;
  - Homemaker services;
  - Maintenance Therapy;

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

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

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

  - If both the donor and recipient have Blue Cross and Blue Shield coverage each will have their benefits paid by their own Blue Cross and Blue Shield program.
  - If a Covered Person is the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Policy will be provided for both the Covered Person and the donor. In this case, payments made for the donor will be charged against the Covered Person's benefits.
  - If a Covered Person is the donor for the transplant and no coverage is available to him/her from any other source, the benefits under this Policy will be provided for him/her. However, no benefits will be provided for the recipient.

  Benefits will be provided for:
  - Inpatient and Outpatient Covered Services related to the transplant Surgery.
  - the evaluation, preparation and delivery of the donor organ.
  - the removal of the organ from the donor.

- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

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

- **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by a Covered Person's Physician, he/she must contact Blue Cross and Blue Shield by telephone before his/her transplant Surgery has been scheduled. Blue Cross and Blue Shield will furnish the Covered Person with the names of Hospitals which have Blue Cross and Blue Shield approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Blue Cross and Blue Shield approved Human Organ Transplant Coverage Program.**
- If a Covered Person is the recipient of the transplant, benefits will be provided for transportation and lodging for him/her and a companion. If the recipient of the transplant is a Dependent child under the limiting age of this Policy, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, a Covered Person's place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
    - The maximum amount that will be provided for lodging is $50 per person per day. Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant.
- In addition to the 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.
    - 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.

- Substance Use Disorder Rehabilitation Treatment: Benefits for all of the Covered Services described in this Policy are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center. Subject to the Preauthorization guidelines set forth in this Policy.
- Mental Illness and Substance Use Disorder Services: Benefits for all of the Covered Services described in this Policy are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorders. Treatment of a Mental Illness or Substance Use Disorder is eligible

when rendered by a Behavioral Health Practitioner working within the scope of their license. Subject to the Preauthorization guidelines set forth in this Policy.

- Detoxification: Benefits for Covered Services received for detoxification will be covered the same as any other condition.
- Autism Spectrum Disorder(s): A Covered Person's benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as his/her benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) a Physician or a Psychologist who has determined that such care is Medically Necessary, or, (b) 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: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.
- Habilitative Services: Benefits for Habilitative Services for Covered Persons with a Congenital, Genetic, or Early Acquired Disorder are the same as Covered Person's benefits for any other condition if all of the following conditions are met:
  - A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
  - Treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and
  - Treatment must be Medically Necessary and therapeutic and not Investigational.
- The processing, transporting, storing, handling and administration of blood and blood components.
- Private Duty Nursing Service: Benefits for Private Duty Nursing Service will be provided to a Covered Person in his/her home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care Provider. No benefits will be provided when a nurse ordinarily resides in a Covered Person's home or is a member of a Covered Person's Immediate Family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available nonprofessional personnel. Benefits for Private Duty Nursing Service are subject to the Preauthorization guidelines set forth in this Policy.

- Naprapathic Service: Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of 15 visits per Benefit Period.
- Bariatric Surgery: Benefits for Covered Services received for Bariatric Surgery will be covered the same as any other condition.
- Routine Pediatric Hearing Examination: Benefits will be provided for routine hearing examinations for children up to age 19.
- Pulmonary Rehabilitation Therapy: Benefits will be provided for Outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and Outpatient pulmonary rehabilitation services.
- Massage Therapy
- Hearing Aids: Benefits will be provided for hearing aids for children up to age 19 limited to two every 36 months. Benefits will also be provided for bone anchored hearing aids.

Mastectomy-Related Services:

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

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care followed a mastectomy for the length of time determined by your attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge;
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; and
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

Virtual Visits:

Benefits will be provided for Covered Services described in this Policy for the diagnosis and treatment of non-emergency medical and behavioral health injuries or illnesses in situations where 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 to provide Virtual Visits to you at the time services are rendered. For more information about this benefit, you may visit our website at *www.bcbsil.com* or call customer service at the number on the back of your identification card.

Benefits for Covered Services you receive through a Virtual Visit will be provided at the payment level shown on the Schedule of Benefits Page of this Policy. 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 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.

Outpatient Prescription Drug Program

- Drug List: The benefit payments of drugs listed on the *Drug List* are selected by Blue Cross and Blue Shield 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. The committee considers drugs regulated by the FDA for inclusion on the *Drug List*. As part of the process, the committee reviews data from clinical studies, published literature and opinions from experts who are not part of the committee. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the *Drug List*. The committee considers drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to this list can be made from time to time. Blue Cross and Blue Shield may offer multiple formularies. Covered Persons will be able to determine the *Drug List* that applies to Covered Persons and whether a particular drug is on the *Drug List*. Drugs that appear on the *Drug List* as Non-Preferred Brand Name Drugs are subject to the Non-Preferred Brand Name Drug payment level plus any pricing differences that may apply to the Covered Drug a Covered Person receives.
- Prior Authorization: Certain Prescription Drugs require a drug's prescribed use to be evaluated against a predetermined set of criteria to determine Medical Necessity before the prescription will be covered. If the approval is not granted, the Covered Person may appeal the decision.
- Step Therapy: When the Covered Person buys a Prescription Drug which has a more cost effective option in the same therapeutic class and is recommended by the Pharmacist, coverage will be limited to the cost of the more cost effective drug.
- Dispensing Limits: If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, coverage will only be provided for a clinically appropriate pre-determined maximum quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.
- Early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the prescribing Physician or Optometrist.
- Controlled Substance Limitation: If Blue Cross and Blue Shield determines that a Covered Person may be receiving quantities of controlled substance medications not supported by

FDA approved dosages or recognized treatment guidelines, any coverage for additional drugs may be subject to a review for Medical Necessity, appropriateness and other coverage restrictions such as limiting coverage to Prescription Orders written by a certain Provider and/or dispensed by a certain Network Pharmacy.

- 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 may limit benefits to specific therapeutic equivalents. If a Covered Person does not choose the therapeutic equivalents that are covered under this benefit section, the drug purchased will not be covered under any benefit level.
- Out-of-Network Pharmacies: When a Covered Person obtains Prescription Drugs, including diabetic supplies from an Out-of-Network Pharmacy (other than a Network Pharmacy), benefits will be provided at 50% of the amount a Covered Person would have received had he/she obtained drugs from a Network Pharmacy minus the Copayment amount or Coinsurance amount.
- Specialty Drugs: In order to receive maximum benefits for Specialty Drugs, a Covered Person must obtain the Specialty Drugs from the preferred Specialty Pharmacy Provider. Specialty Drugs obtained from all other pharmacies will be provided at 50% of the amount a Covered Person would have received had he/she obtained drugs from a Specialty Pharmacy Provider.

Injectable Drugs

Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

Diabetic Supplies for Treatment of Diabetes

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

- Test strips specified for use with a corresponding blood glucose monitor
- 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
- Glucagon emergency kits

Immunosuppressant Drugs

Benefits are available for Medically Necessary immunosuppressant drugs with a written prescription after an approved Human Organ Transplant.

Fertility Drugs

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

Opioid Antagonists

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

Vaccinations obtained through Network Pharmacies

Benefits for vaccinations are available through certain Network Pharmacies that have contracted with Blue Cross and Blue Shield to provide this service. To locate one of these contracting Network Pharmacies in a Student's area and to find out which vaccinations are covered, they can call Customer Service at 1-855-267-0214 or access the website at *www.bcbsil.com*.

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

Benefits for vaccinations that are considered preventive care services will not be subject to any Deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Network Provider or Network 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 Out-of-Network Pharmacists, or other routine Covered Services not provided for under this provision may be subject to the Deductible, Coinsurance, Copayments and/or benefit maximums.

Emergency Services:

If the Covered Person must be hospitalized in an Out-of-Network Hospital immediately following Emergency Accident Care or Emergency Medical Care, benefits will be provided at the Network Provider Hospital payment level for that portion of the Covered Person's Inpatient Hospital stay during which the Covered Person's condition is reasonably determined by Blue Cross and Blue Shield of Illinois to be serious and therefore not permitting the Covered Person's safe transfer to a

Network Hospital or other Network Provider. For that portion of the Covered Person's Inpatient Hospital stay during which the Covered Person's condition is reasonably determined by Blue Cross and Blue Shield of Illinois not to be serious, benefits will be provided at 50% of the Allowable Amount for Covered Services if the Covered Person is in a Non-Plan Hospital, or at the Out-of-Network Provider Hospital payment level if the Covered Person is in an Out-of-Network Hospital. In order for the Covered Person to continue to receive benefits at the Network Hospital payment level following an emergency admission to an Out-of-Network Hospital, the Covered Person must transfer to a Network Hospital or other Network Provider as soon as the Covered Person's condition is no longer serious. To identify Plan Hospitals or facilities, the Covered Person should contact Blue Cross and Blue Shield of Illinois by calling customer service at 1-855-267-0214 or visit Our website at *www.bcbsil.com*.

Case Management for Complex Care Services:

Case management is a collaborative process that assists Covered Persons with the coordination of complex care services. After a Covered Person's case has been evaluated, the Covered Person may be assigned a case manager. In some cases, if the Covered Person's condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan. If a Covered Person and his/her Physician choose the alternative treatment plan, then alternative benefits will be provided as described in this Policy. The case manager will continue to monitor the Covered Person's case for the duration of the condition. The total maximum payment for alternative services shall not exceed the total benefits for which the Covered Person 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 of this Policy.

ADDITIONAL BENEFITS

NOTICE OF CERTAIN MANDATORY BENEFITS

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

Cancer Clinical Trials Benefit

Benefits will be provided for routine patient care in conjunction with investigational treatments when medically appropriate and a Covered Person has a terminal condition that according to the diagnosis of a Covered Person's Physician is considered a Life Threatening Disease or Condition if a) a Covered Person is a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this Policy if not provided in connection with an Approved Clinical Trial program. Blue Cross and Blue Shield will not terminate or non-renew a Student's coverage under this Policy due to participation in an Approved Clinical Trial program. A Covered Person and his/her Physician are encouraged to call Customer Service at 1-855-267-0214 in advance to obtain information about whether a particular clinical trial is qualified. Benefits for expenses covered under this provision will be subject to all of the terms and conditions of the group health Policy notwithstanding and payable to the same extent as any other medical expenses covered by the group Policy.

Preventive Care Services

In addition to the benefits otherwise provided for in this Policy, (and notwithstanding anything in this Policy to the contrary), the following benefits for preventive care services will be considered Covered Services and will not be subject to any Deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Network Provider or a Network 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; and
- with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

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

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, Covered Persons may access the website at *www.bcbsil.com* or they can call Customer Service at 1-855-267-0214.

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

1. Abdominal aortic aneurysm screening for men who have ever smoked

2. Alcohol misuse screening and counseling

3. Aspirin use for men and women of certain ages

4. Blood pressure screening

5. Cholesterol screening for adults of certain ages or at higher risk

6. Colorectal cancer screening for adults over age 50

7. Depression screening

8. Type 2 diabetes screening for adults with high blood pressure

9. Diet counseling for adults at higher risk for chronic disease

10. HIV screening for all adults at higher risk

11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):

- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human papillomavirus
- Influenza (Flu shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

12. Obesity screening and counseling

13. Sexually transmitted infections (STI) prevention

14. Tobacco use screening and cessation interventions for tobacco users

15. Syphilis screening for adults at higher risk

16. Physical Therapy to prevent falls in adults age 65 years and older who are at increased risk for falls

17. Hepatitis C virus (HCV) screening for persons at high risk for infection

18. One-time HCV infection screening of adults born between 1945 and 1965

19. Hepatitis B virus screening for persons at high risk for infection

20. Counseling children, adolescents, and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer

21. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 and older

22. Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls

23. Screening for high blood pressure in adults age 18 years or older

24. Screening for abnormal blood glucose and type II diabetes mellitus as part of cardiovascular risk assessment in adults who are overweight or obese.

25. Screening for latent tuberculosis for adults at higher risk of tuberculosis.

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

1. Anemia screening on a routine basis for pregnant women

2. Bacteriuria urinary tract screening or other infection screening for pregnant women

3. BRCA counseling about genetic testing for women at higher risk

4. Breast cancer mammography screenings, including breast tomosynthesis and, if Medically Necessary, a screening MRI.

5. Breast cancer chemoprevention counseling for women at higher risk

6. Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Electric breast pumps are limited to 2 per benefit period.

7. Cervical cancer screening for sexually active women

8. Chlamydia infection screening for younger women and women at higher risk

9. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling

10. Domestic and interpersonal violence screening and counseling for all women

11. Folic acid supplements for women who may become pregnant

12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes

13. Gonorrhea screening for all women at higher risk

14. Hepatitis B screening for pregnant women at their first prenatal visit

15. HIV screening and counseling for sexually active women and pre-natal HIV testing

16. 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

17. Osteoporosis screening for women over age 60, depending on risk factors

18. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk

19. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users

20. Sexually transmitted infections (STI) counseling for sexually active women

21. Syphilis screening for all pregnant women or other women at increased risk

22. Well-woman visits to obtain recommended preventive services.

23. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal

24. Hepatitis C virus (HCV) screening for persons at high risk for infection

25. One-time HCV infection screening of adults born between 1945 and 1965

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

1. Alcohol and drug use assessment for adolescents

2. Behavioral assessments for children of all ages

3. Blood pressure screenings for children of all ages

4. Cervical dysplasia screening for sexually active females

5. Congenital hypothyroidism screening for newborns

6. Major depression disorder (MDD) screening for adolescents

7. Development screening for children under age 3, and surveillance throughout childhood

8. Dyslipidemia screening for children at higher risk of lipid disorder

9. Fluoride chemoprevention supplements for children without fluoride in their water source

10. Gonorrhea preventive medication for the eyes of all newborns

11. Hearing screening for all newborns

12. Height, weight and body mass index measurements

13. Hematocrit or hemoglobin screening

14. Hemoglobinopathies or sickle cell screening for all newborns

15. HIV screening for adolescents at higher risk

16. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):

- Hepatitis A
- Hepatitis B
- Human papillomavirus
- Influenza (Flu shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella
- Haemophilus influenzae type b
- Rotavirus

- Inactivated Poliovirus

17. Iron supplements for children ages 6 to 12 months at risk for anemia

18. Lead screening for children at risk for exposure

19. Medical history for all children throughout development

20. Obesity screening and counseling

21. Oral health risk assessment for younger children up to ten years old

22. Phenylketonuria (PKU) screening for newborns

23. Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk

24. Tuberculin testing for children at higher risk of tuberculosis

25. Vision screening for all children

26. Autism screening

27. Hepatitis C virus (HCV) screening for persons at high risk for infection

28. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents

29. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

The FDA approved contraceptive drugs and devices currently covered under this benefit provision are listed on the Contraceptive Drugs & Devices List. This list is available on Our website at *www.bcbsil.com* and by contacting Customer Service at 1-855-267-0214. Benefits are not available under this benefit provision for Contraceptive drugs and devices not listed on the Contraceptive Drugs & Devices List. A Covered Person may, however, have coverage under other sections of this Policy, subject to any applicable Coinsurance, Copayments, Deductibles and/or benefit maximum. The Contraceptive Drugs & Devices List and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

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

Preventive care services received from an Out-of-Network Provider, a Non-Plan Provider facility, or an Out-of-Network Pharmacy or other routine Covered Services not provided for under this provision may be subject to the Deductible, Coinsurance, Copayment and/or benefit maximum.

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

Benefits for vaccinations that are considered preventive care services will not be subject to any Deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Network Provider or Network 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 Out-of-Network Pharmacists, or other routine Covered Services not provided for under this provision may be subject to the Deductible, Coinsurance, Copayments and/or benefit maximums.

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

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

Pediatric Vision Care

This *Pediatric Vision Care Section* is made part of, and is in addition to any information a Policyholder 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 a Covered Person's medical/surgical benefits of this Policy. **(Services that are covered under a Covered Person's medical/surgical benefits of this Policy are not covered under this *Pediatric Vision Care Section*.) All provisions in this Policy apply to this *Pediatric Vision Care Section* unless specifically indicated otherwise below.**

Benefits for Pediatric Vision Care are administered by Blue Cross and Blue Shield. Blue Cross and Blue Shield has contracted with EyeMed Vision Care, LLC ("EyeMed"). EyeMed provides customer service and claims administration services for Pediatric Vision Care. The relationship between Blue Cross and Blue Shield and EyeMed is that of independent contractors. Through our arrangement with EyeMed, Covered Persons will have access to EyeMed's network of vision care Providers.

This BCBSIL vision care plan allows Covered Persons to select the Provider of their choice, in or out of the Network. Covered Persons will have a higher benefit level if they choose to receive Pediatric Vision Care services from a Network Provider.

Definitions

Benefit Period – For purposes of this *Pediatric Vision Care Section*, a period of time that begins on the later of: 1) the Covered Person's Effective Date of coverage under this *Pediatric Vision Care Section*, or 2) 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 of a group or family.)

Provider – For purposes of this *Pediatric Vision Care Section*, a licensed ophthalmologist or Optometrist operating within the scope of his or her 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 benefits 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 a Covered Person's failure to comply with professionally prescribed treatment
- telephone consultations
- any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances
- office injection control charges
- charges for copies of Covered Person's records, charts, or any costs associated with forwarding/mailing copies of Covered Person's 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
- two pairs of eyeglasses in lieu of bifocals
- services not performed by licensed personnel
- prosthetic devices and services
- insurance of contact lenses
- professional services a Covered Person receives from immediate relatives or household members, such as a spouse, 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, unless otherwise covered through warranty
- services of unlicensed personnel

How the Vision Care Plan Works

Under the vision care plan option, a Covered Person may visit any covered Provider and receive benefits for a vision examination. In order to maximize benefits for most covered Vision Materials, however, a Covered Person must purchase them from a Network Provider.

Before a Covered Person goes to a Network vision care plan Provider for an eye examination, eyeglasses, or contact lenses, he/she should call ahead for an appointment. When a Covered Person arrives, he/she should show the receptionist their Identification Card. If a Covered Person forgets to take their card,

he/she should say that he/she is a member of the BCBSIL vision care plan so that his/her eligibility can be verified.

To locate a Network vision care Provider, Covered Persons can visit Our website at *www.bcbsil.com*, or Students can contact Customer Service at 1-844-684-2254 to obtain a list of the Network vision care plan Providers nearest them.

If a Covered Person obtain glasses or contacts from an Out-of-Network Provider, he/she must pay the Provider in full and submit a Claim for reimbursement (Covered Persons should see the **CLAIM PROVISIONS** section of this Policy for more information).

A Covered Person may receive his/her 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 Network Provider and there may be additional professional charges if a Covered Person seeks contact lenses from a Provider other than the one who performed his/her eye 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 the Covered Person to the Provider, whether or not the Provider participates in the vision care plan network. Benefits under this *Pediatric Vision Care 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.

Schedule of Pediatric Vision Coverage

Vision Care Services	**In-Network Covered Person Cost or Discount** (When a fixed-dollar Copayment is due from the Covered Person, the remainder is payable by the Policy up to the covered charge**)	**Out-of-Network Allowance** (Maximum amount payable under this Policy, not to exceed the retail cost)****
Exam (with dilation as necessary):	No Copayment	Up to $30
Frames:		
Provider-Designated frame*** Note: Provider-Designated frames with retail value up to $225 are available at no cost at most participating independent Providers. Retail chain Providers are required to maintain a comparable selection of frames.	No Copayment on provider-designated frame; $150 allowance on non-provider designated frame, 20% off balance over $150.	Up to $75
Additional Pairs Benefit:*	Members also receive a 40% discount off complete pair eyeglass purchases and 15%	Not Covered

	discount off conventional contact lenses once the funded benefit has been used.	
Frequency:		
Examination, Lenses, or Contact Lenses	Once every 12-month Benefit Period	
Frame	Once every 12-month Benefit Period	
Standard Plastic, Glass, or Poly Spectacle Lenses:		
Single Vision	No Copayment	Up to $25
Bifocal	No Copayment	Up to $40
Trifocal	No Copayment	Up to $55
Lenticular	No Copayment	Up to $55
Standard Progressive Lens	No Copayment	Up to $55
Premium Progressive Lens Tier 1*	$20 Copayment	Not Covered
Premium Progressive Lens Tier 2*	$30 Copayment	Not Covered
Premium Progressive Lens Tier 3*	$45 Copayment	Not Covered
Premium Progressive Lens Tier 4*	$0 Copay, 80% of charge less $120 Allowance	Not Covered

Lens Options (add to lens prices above):		
UV Treatment	No Copayment	$12
Tint (Fashion & Gradient & Glass-Grey)	No Copayment	Not Covered
Standard Plastic Scratch Coating	No Copayment	$12
Standard Polycarbonate- Adults*	$40 Copayment	Not Covered
Standard Polycarbonate- Kids under 19	No Copayment	$32
Standard Anti-Reflective Coating*	$45 Copayment	Not Covered
Premium Anti-Reflective Coating Tier 1*	$57 Copayment	Not Covered
Premium Anti-Reflective Coating Tier 2*	$68 Copayment	Not Covered
Premium Anti-Reflective Coating Tier 3*	20% off Retail Price	Not Covered
Polarized*	20% off Retail Price	Not Covered
Glass	No Copayment	$12
Photochromic / Transitions Plastic	No Copayment	$57
Oversized	No Copayment	Not Covered
Other Add-Ons*	20% off Retail Price	Not Covered

Contact Lenses:		
(Contact lens allowance includes materials only)	100% coverage for provider-designated contact lenses	
Extended Wear Disposables	Up to 6 mos supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	Up to $150
Daily Wear / Disposable	Up to 3 mos supply of daily disposable, single vision spherical contact lenses	Up to $150
Conventional	1 pair from selection of provider-designated contact lenses	$150
Medically Necessary contact lenses	$0 Copay, Paid-in-Full	$210
Note: In some instances, participating Providers may charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, a Covered Person may submit a Claim for the remaining balance (the combined reimbursement will not exceed the total allowance).		
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: A Covered Person will receive a discount for traditional LASIK and custom LASIK from participating Physicians and contracted laser centers. *Prices/discounts may vary by state and are subject to change without notice.*

Mail-order contact lens replacement: *www.contactsdirect.com*

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 covered in lieu of other eyewear.

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

Members who require low-vision services and optical devices are entitled to the following coverage, both in-and-out-of network: **Low Vision Evaluation:** One comprehensive evaluation every five years. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems, perceiving contrast and lightning requirements for optimum vision.
Low-Vision Aid: Covered for one device per year such as high-power spectacles, magnifiers and telescopes. These devices are utilized to maximize use of available vision, reduce problems of glare or increase contract perception, based on the individual's visual goals and lifestyle needs. **Follow-up care:** Four visits in any five-year period.
Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Covered Persons should ask their Provider for details of the warranty that is available to them.

*Value-Added Features – In-Network Providers may offer discounted prices for non-covered lenses. Discounted prices may vary by state and are subject to change or discontinuance at any time without notice. THE DISCOUNTS ARE NOT INSURANCE.
**The "covered charge" is the rate negotiated with Network Providers for a particular Covered Service.
***In an Out-of-Network Benefit Offering and Non-Provider-Designated frames: Frames covered by this Policy are limited to the Provider-Designated frames. The network Provider will show you the selection of frames covered by this Policy. If you select a frame that is not included in the Provider-Designated frames covered under this Policy, you are responsible for the difference in cost between the network Provider reimbursement amount for covered Provider-Designated frames and the retail price of the frame selected. If frames are provided by a non-network Provider, benefits are limited to the amount shown above in the "Schedule of Benefits." Any amount 1) paid to the network Provider for the difference in cost of a non-Provider-Designated frame or 2) that exceeds the Maximum Covered Fee for a non-network Provider supplied frame will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket Maximum/out-of-pocket limit/out-of-pocket Coinsurance maximum.
****The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.

EXCLUSIONS AND LIMITATIONS

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 or Hospital, or by any person employed by the University;
- acupuncture procedures;
- bio-feedback 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 28 days of birth;
- any charges for Surgery, procedures, treatment, facilities, supplies, devices, or drugs that the Insurer determines are Experimental or Investigational;
- expenses incurred for Injury or Sickness arising out of or in the course of a Covered Person's employment, regardless if benefits are, or could be paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
- 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 the Covered Person to pay for the treatment;
- blood derivatives which are not classified as drugs in the official formularies.
- expenses in connection with services and prescriptions for eye examinations, eye refractions, eye glasses 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;
- expenses in connection with cosmetic treatment or cosmetic Surgery, except as a result of:
  - a covered Injury that occurred while the Covered Person was insured;
  - an infection or other diseases of the involved part; or
  - a covered child's congenital defect or anomaly;
- Injuries arising from Interscholastic Activities and Qualifying Intercollegiate Sports;
- 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, sail planing, 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 of any country or international authority;
- any expenses incurred in connection with sterilization reversal or vasectomy reversal;
- services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy;
- 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 the repair of Injuries to sound natural teeth caused by a covered Injury;
- foot care including: flat foot conditions, subluxations, care of corns, bunions (except capsular or bone Surgery), calluses, toenails, fallen arches, weak feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care;
- hearing examinations; hearing aids; or other treatment for hearing defects or problems, except as provided for children and for bone anchored hearing aids (osseointegrated auditory implants) as described in the Benefit Description section of this Policy. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
- hirsutism;
- alopecia;
- gynecomastia;
- weight management, weight reduction, or treatment for obesity including any condition resulting there from, including hernia of any kind;
- surgery for the removal of excess skin or fat;
- Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Policy. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases;
- Custodial Care Service;
- Long Term Care Service;
- Inpatient Private Duty Nursing Service;
- weight loss programs;
- Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services;

- 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;
  - 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.;
  - fertility agents or 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, except when used to treat Medically Necessary Covered Services resulting from an organic disease or illness, Injury or congenital defect;
  - lost or stolen prescriptions;
  - non-sedating antihistimines;
  - compound medications;
  - weight loss medications;
  - proton pump inhibitors;
  - drugs determined by the Plan to have inferior efficacy or significant safety issues.

NON-DUPLICATION OF BENEFITS LIMITATION

If benefits are payable under more than one (1) benefit provision contained in the Policy, benefits will be payable only under the provision providing the greater benefit.

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION

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

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

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

1. Non-Dependent or Dependent

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

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

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

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

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

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

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

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

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

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

4. Dependent Child if Parents Share Joint Custody

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

5. Young Adult as a Dependent

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

6. Active or Inactive Employee

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

7. Continuation Coverage

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

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

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

8. Length of Coverage

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

The benefits of this Benefit Program will be reduced when:

- The benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
- The benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a Claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Benefit Program will be reduced so that they and the benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

If the Covered Person are eligible for Medicare Part B, the benefits of this Benefit Program may be reduced taking into consideration the amount that would be payable for an Allowable Expense under Medicare Part B whether or not the Covered Person has enrolled in Part B and/or received payment from Medicare.

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

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

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

CLAIM PROVISIONS

Notice of Claim: Written (or authorized electronic or telephonic) notice of a Claim under the Policy must be given to the Insurer or the Administrator within 20 days after any loss covered by the Policy occurs, or as soon thereafter as is reasonably possible. The notice should identify the Covered Person and the Policy number.

Claim Forms: Upon receipt of a written notice of Claim, the Insurer or Administrator will send Claim forms to the claimant within 15 days. If the forms are not furnished within 15 days, the claimant will satisfy the Proof of Loss requirements of the Policy by submitting written proof describing the occurrence, nature and extent of the loss for which Claim is made.

Proofs of Loss: Written (or authorized electronic or telephonic) proof of loss must be furnished to the Insurer or its Administrator within 90 days after the date of loss. Failure to furnish proof within the time required will not invalidate nor reduce any Claim if it is not reasonably possible to give proof within 90 days, provided:

- it was not reasonably possible to provide proof in that time; and
- the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity.

Written Proof of Loss for services or supplies provided by a Network Provider must be furnished to Us by the Network Provider in strict compliance with the written contract between Us and the Network Provider. In the event such written contract does not contain a time limitation for furnishing Proof of Loss, the provisions above shall be applicable.

Time for Payment of Claim: Benefits payable under the Policy will be paid promptly, but in no event later than 30 days following receipt of satisfactory written proof of loss.

Payment to Possessory or Managing Conservator of Dependent Child

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

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

Initial Claims Determinations

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

If a Claim Is Denied or Not Paid in Full

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

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

An "urgent care/expedited clinical Claim" is any pre-service Claim for benefits for Medical Care treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to

regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

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

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

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

a. The reasons for denial;
b. A reference to the benefit plan provisions on which the denial is based;
c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), 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;
e. An explanation of Blue Cross and Blue Shield of Illinois's internal review/appeals and external review processes (and how to initiate a review/appeal or external review); Specifically, this explanation will include:

    1. An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);

    2. An explanation that you may ask for an external review with an Independent Review Organization (IRO) not associated with Blue Cross and Blue Shield 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 failed to give you a timely decision (see 4. below), and your claim was denied for one of these reasons:

        - A decision about the medical need for or the experimental status of a recommended treatment

- A condition was considered pre-existing
- Your health care coverage was rescinded (See your Benefit Booklet for details)

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

3. An explanation that you may ask for an expedited (urgent) external review if:
    - 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;
    - Blue Cross and Blue Shield failed to give you a decision within 48 hours of your request for an expedited appeal; or
    - The request for treatment is experimental or investigational and your health care provider states in writing that the treatment would be much less effective if not promptly started;
4. If the written notice is for a Final Adverse Determination, the notice will include an explanation that you may ask for an expedited (urgent) external review if the Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility;
5. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield 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 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 claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
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 the claimant within 3 days of oral notification; and
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
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

122 S. Michigan Avenue, 19th floor
Chicago, IL 60603
312-814-2420 phone
312-814-5416 fax

For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Inquiries and Complaints

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

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

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

- Claims
- Quality of care

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

To pursue an Inquiry or Complaint, the Covered Person may contact **Customer Service** at the number on the back of the Covered Person's ID card, or the Covered Person may write to:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

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

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

Claim Appeal Procedures — Definitions

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

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

An **"Adverse Determination"** means:

A. 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;

B. The denial, reduction or termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Blue Cross and Blue Shield or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or

C. A rescission of coverage determination, which does not include a cancellation of or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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

Claim Appeal Procedures

If the Covered Person has received an Adverse Benefit Determination, the Covered Person may have the Covered Person's Claim reviewed on appeal. Blue Cross and Blue Shield of Illinois will review its decision in accordance with the following procedures. The following review procedures will also be used for Blue Cross and Blue Shield of Illinois (i) coverage determinations that are related to non-urgent care that the Covered Person have not yet received if approval by the Covered Person's plan is a condition of the Covered Person's opportunity to maximum the Covered Person's benefits and (ii) coverage determinations that are related to care that the Covered Person is receiving at the same time as the determination. Claim reviews are commonly referred to as "appeals."

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

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

In support of the Covered Person's Claim review, the Covered Person has the option of presenting evidence and testimony to Blue Cross and Blue Shield of Illinois. The Covered Person and the Covered Person's authorized representative may ask to review the Covered Person's file and any relevant documents and may submit written issues, comments and additional medical information within 180 days

after the Covered Person receives notice of an Adverse Benefit Determination or at any time during the Claim review process.

To contact Blue Cross and Blue Shield to request a Claim review or appeal an Adverse Benefit Determination, use the following contact information:

Claim Review Section
Blue Cross and Blue Shield
P.O. Box 2401
Chicago, IL 60690-1364
1-800-538-8833 Toll-free number
1-888-235-2936 Fax number
1-918-551-2011 Fax number for Urgent requests
Send a secure email by using our message center by logging into Blue Access for Members℠ (BAM) at *www.bcbsil.com*

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

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

Urgent Care/Expedited Clinical Appeals

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

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, Blue Cross and Blue Shield of Illinois will notify the party filing the appeal, as soon as possible, but no more than 24 hours

after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. Blue Cross and Blue Shield of Illinois shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by Blue Cross and Blue Shield of Illinois.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal Blue Cross and Blue Shield of Illinois shall rendered a determination of the appeal within 3 business days if additional information is needed to review the appeal. Additional information must be submitted within 5 days of the request. Blue Cross and Blue Shield of Illinois shall render a determination of the appeal within 15 business days after it receives the requested information but in no event more than 30 days after the appeal has been received by Blue Cross and Blue Shield of Illinois.

If the Covered Person Needs Assistance

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

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

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

Notice of Appeal Determination

Blue Cross and Blue Shield of Illinois will notify the party filing the appeal, the Covered Person, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

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:

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 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 failed to give you a timely decision (see 4. below), and your claim was denied for one of these reasons:

- A decision about the medical need for or the experimental status of a recommended treatment
- A condition was considered pre-existing
- Your health care coverage was rescinded (See your Benefit Booklet for details)

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:

- 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;
- Blue Cross and Blue Shield failed to give you a decision within 48 hours of your request for an expedited appeal; or
- 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;

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 the covered person 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 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 sends you a written decision within 48 hours of your request for an expedited appeal;

5. 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);
6. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield of Illinois.
7. 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;
8. 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;
9. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and
10. A description of the standard that was used in denying the Claim and a discussion of the decision.

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

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

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

The Illinois Department of Insurance can be contacted at:

For complaints and general inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, IL 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

122 S. Michigan Avenue, 19th floor
Chicago, IL 60603
312-814-2420 phone
312-814-5416 fax

For external review requests:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

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

Independent External Review

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

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

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

1. Standard External Review

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

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

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

122 S. Michigan Avenue, 19th floor
Chicago, IL 60603
312-814-2420 phone
312-814-5416 fax

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

a. Preliminary Review. Within 5 business days of receipt of the Covered Person's request, Blue Cross and Blue Shield of Illinois will complete a preliminary review of the Covered Person's request to determine whether:
    - the Covered Person was covered at the time health care service was requested or provided;
    - The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this benefit program, but Blue Cross and Blue Shield of Illinois has determined that the health care service does not meet Blue Cross and Blue Shield of Illinois's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
    - the Covered Person has exhausted Blue Cross and Blue Shield of Illinois's internal grievance process (in certain urgent cases, the Covered Person may be eligible for expedited external review even if the Covered Person has not filed an internal appeal with Blue Cross and Blue Shield of Illinois, and , the Covered Person may also be eligible for external review if the Covered Person filed an internal appeal but have not received a decision from Blue Cross and Blue Shield of Illinois within 15 days after Blue Cross and Blue Shield of Illinois received all required information in no case longer than 30 days after the Covered Person first filed the appeal or within 48 hours if the Covered Person has filed a request for an expedited internal appeal); and
    - the Covered Person has provided all the information and forms required to process an external review.

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

- Standard health care services or treatments have not been effective in improving the Covered Person's condition;
- Standard health care services or treatments are not medically appropriate for the Covered Person;

- There is no available standard health care services or treatment covered by Blue Cross and Blue Shield of Illinois that is more beneficial than the recommended or requested service or treatment;
- The health care service or treatment is likely to be more beneficial to the Covered Person, in the opinion of the Covered Person's health care Provider, than any available standard health care services or treatments; or
- That scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to the Covered Person than any available standard health care services or treatments.

b. **Notification.** Within 1 business day after completion of the preliminary review, Blue Cross and Blue Shield of Illinois shall notify the Covered Person and the Covered Person's authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the Covered Person shall be notified by Blue Cross and Blue Shield of Illinois in writing of what materials are required to make the request complete or the reason for its ineligibility. Blue Cross and Blue Shield of Illinois's determination that the external review request is ineligible for review 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 the Covered Person's benefit program and shall be subject to all applicable laws.

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

Upon assignment of an IRO, Blue Cross and Blue Shield of Illinois or its designated utilization review organization shall, within 5 business days, provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, the Covered Person or the Covered Person's authorized representative may, within 5 business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 5 business days. If Blue Cross and Blue Shield of Illinois or its designated utilization review organization does not provide the documents and information within 5 business days, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by Blue Cross and Blue Shield of Illinois or designated utilization review organization to provide the documents and information to the IRO within 5 business days shall not delay the conduct of the external review. Within 1 business day after making the decision to end the external review, the IRO shall notify Blue Cross and Blue Shield of Illinois, the Covered Person and, if applicable, the Covered Person's authorized representative, of its decision to reverse the determination.

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

d. **IRO's Decision.** In addition, to the documents and information provided by Blue Cross and Blue Shield of Illinois and the Covered Person, or if applicable, the Covered Person's authorized representative, the IRO shall also consider the following information if available and appropriate:
    - the Covered Person's medical records;
    - the Covered Person's health care Provider's recommendation;
    - Consulting reports from appropriate health care Providers and associated records from health care Providers;
    - The terms of coverage under the benefit program;
    - The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
    - Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield of Illinois or its designated utilization review organization;
    - The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above, for a denial of coverage based on a determination that the health care service or treatment recommended or requested is Experimental or Investigational, whether and to what extent (a) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, (b) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment would be substantially increased over those of available standard health care services or treatments, or (c) the terms of coverage under the Covered Person's benefit program to ensure that the health care services or treatment would otherwise be covered under the terms of coverage of the Covered Person's benefit program.

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

The written notice will include:

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

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

1. A description of the Covered Person's medical condition;
2. A description of the indicators relevant to whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatments would not be substantially increased over those of available standard health care services or treatments;
3. A description and analysis of any medical or scientific evidence considered in reaching the opinion;
4. A description and analysis of any evidence-based standards;
5. Whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration;
6. Whether medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
7. 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.

2. Expedited External Review

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

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

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

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

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

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

Within 2 business days after the date of receipt of all necessary information, the expedited independent external reviewer will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and the Covered Person will receive notification from Blue Cross and Blue Shield of Illinois. Until July 1, 2013, if the Covered Person disagrees with the determination of the external independent reviewer, the Covered Person may contact the Illinois Department of Insurance.

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

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

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

BlueCard:

I. 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 Blue Cross Blue Shield Association. Whenever a Covered Person accesses healthcare services outside of the Plan's service area, the Claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program and may include negotiated arrangements available between the Plan and other Blue Cross and Blue Shield Licensees.

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

A. BlueCard® Program

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

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

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

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

a. Suppose a Covered Person receives covered services for an illness while he/she is on vacation outside of Illinois. A Covered Person shows his/her identification card to the Provider to let him or her know that he/she is covered by the Plan.
b. The Provider has negotiated with the Host Blue a price of $80, even though the Provider's standard charge for this service is $100. In this example, the Provider bills the Host Blue $100.
c. The Host Blue, in turn, forwards the Claim to the Plan and indicates that the negotiated price for the Covered Service is $80. The Plan would then base the amount a Covered Person must pay for the service -- the amount applied to his/her Deductible, if any, and his/her Coinsurance percentage -- on the $80 negotiated price, not the $100 billed charge.
d. So, for example, if a Covered Person's Coinsurance is 20%, he/she would pay $16 (20% of $80), not $20 (20% of $100). A Covered Person is not responsible for amounts over the negotiated price for a Covered Service.

PLEASE NOTE: The Coinsurance percentage in the above example is for illustration purposes only. The example assumes that a Covered Person has met his/her Deductible and that there are no Copayments associated with the service rendered. A Covered Person's Deductible(s), Coinsurance and Copayment(s) are specified in this Policy.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to a Covered Person's Provider. Sometimes, it is an estimated price that takes into account special arrangements with a Covered Person's Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

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

Non-Participating Providers Outside the Plan's Service Area

1. Liability Calculation

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

2. Exceptions

In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion, negotiate a payment with such Non-Participating Provider on an exception basis.

B. 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.

C. BlueCard Worldwide® Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program 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 BlueCard Worldwide 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 BlueCard Worldwide 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 BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact the Plan to obtain preauthorization for non-emergency Inpatient Services.**

- **Outpatient Services**

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

- **Submitting a BlueCard Worldwide 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 BlueCard Worldwide International claim form and send the claim form with the Provider's itemized bill(s) to the BlueCard Worldwide 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 BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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

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

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

Physical Examination and Autopsy: We have the right to have a Doctor of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a Claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. Such examinations or autopsy will be at the expense of the Insurer.

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

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

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

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

ADMINISTRATIVE PROVISIONS

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

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

- The terms of the Policy change.
- A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
- 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. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

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

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

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

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

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

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

ParPlan Provider Arrangement

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

- file all Claims for the Covered Person;
- accept the Allowable Amount determination as payment for Medically Necessary services, and
- not bill the Covered Person for services over the Allowable Amount determination.

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

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

GENERAL PROVISIONS

Entire Contract: The entire contract consists of the Policy (including any endorsements or amendments), the signed application of the Policyholder, the Student enrollment form, benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a Claim for loss incurred unless it is contained in a written application.

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

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

Policy Effective Date: The Policy begins on the Policy Effective Date at 12:00 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. Either We or the Policyholder may terminate this Policy on any Premium due date by giving 31 day advance written (authorized electronic or telephonic) notice to the other. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Policyholder and Us.

This Policy terminates automatically on the earlier of:

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

Termination takes effect at 11:59 PM, Standard Time at the address of the Policyholder on the date of termination.

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

a. **Rebate.** In the event federal or state law requires Blue Cross and Blue Shield to rebate a portion of annual premiums paid, Blue Cross and Blue Shield will provide any rebate as required or allowed by such federal or state law.
b. **Abatement.** Blue Cross and Blue Shield 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 represents a determination by Blue Cross and Blue Shield not to collect premium for the applicable period(s) and does not effect 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.

c. Blue Cross and Blue Shield 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.
d. **Cost-sharing.** Blue Cross and Blue Shield reserves the right to waive or reduce the Coinsurance, Copayments and/or Deductibles under this Policy.

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

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

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

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

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

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

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

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

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 its list of clients.

Our Separate Financial Arrangements Regarding Prescription Drugs:

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

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

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

Separate Financial Arrangements with Pharmacy Benefit Managers:

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

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

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

The personal and confidential nature of the requested documents, records and other information

Release of the Confidential Information may also reveal Our confidential, business proprietary and trade secret information

To maintain the confidentiality of the Confidential Information and any Proprietary Information

The third party consultant and/or vendor shall:

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

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

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

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

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

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

Identity Theft Protection Services: As a Member Blue Cross and Blue Shield of Illinois makes available at no additional cost to the Policyholder identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect the Policyholder's information. These identity theft protection services are currently provided by Blue Cross and Blue Shield of Illinois' designated outside vendor and acceptance or declination of these services is optional to the Member. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at *www.bcbsil.com* or telephonically by calling the toll free number on your identification card. Services may automatically end when the person is no longer an eligible Member. Service may change or be discontinued at any time with or without notice and Blue Cross and Blue Shield 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 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 the aforementioned paragraph the term "Member" means the group, trust, association or other entity to which this Policy has been issued. It does not include Covered Persons under the Policy. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in the Policy to "premium(s)" shall mean "charge(s)." Blue Cross and Blue Shield pays indemnification or advances expenses to a director, officer, employee or agent consistent with Blue Cross and Blue Shield's bylaws then in force and as otherwise required by applicable law.

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

Rescission of Coverage: Any act, practice, or omission that constitutes fraud, or any intentional misrepresentation made by or on behalf of anyone seeking coverage under this Policy, may result in the cancellation of the Covered Person's coverage (and/or the Covered Person's dependent(s) coverage) retroactive to the Effective Date – (a "Rescission"), subject to 30 days prior notification. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates. Any intentional fraudulent misstatement or omissions, or intentional misrepresentation of a material fact on the Covered Person's application, or any practice that constitutes fraud may result in a Rescission of the Covered Person's coverage (and/or the Covered Person's

dependent(s) coverage) retroactive to the Effective Date, subject to prior notification. The Covered Person has the right to appeal this Rescission and an independent third party may review the decision. In the event of Rescission, Blue Cross and Blue Shield 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.