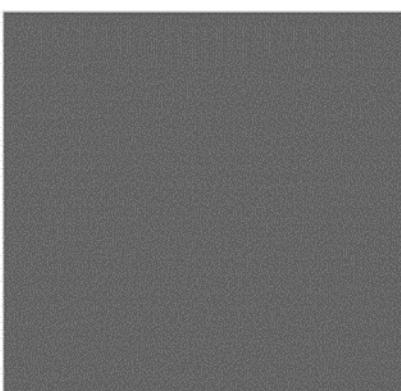
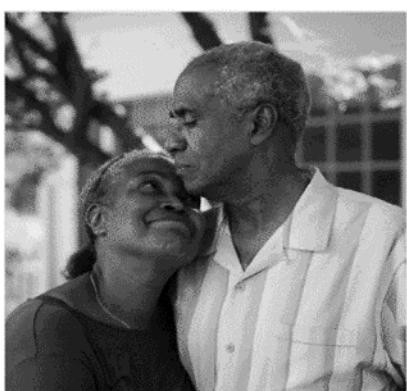
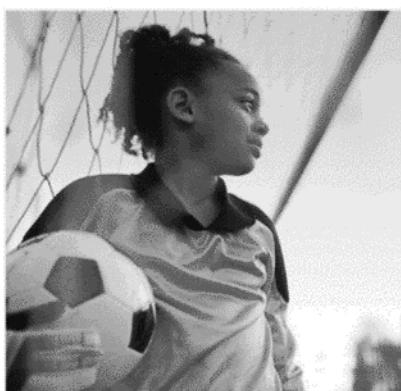
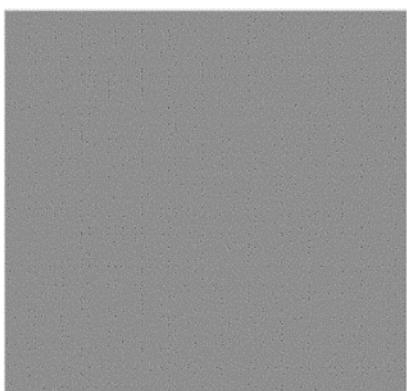
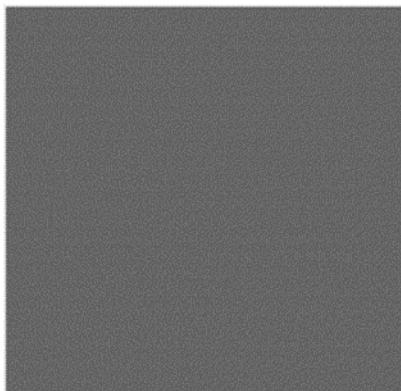
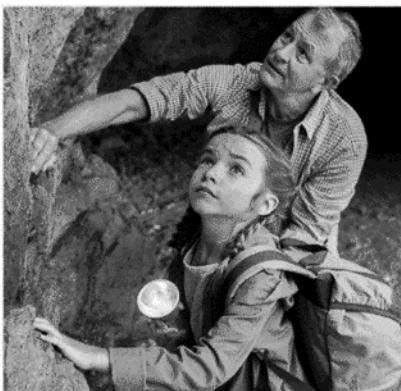




**BlueCross BlueShield of Illinois**

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



## Your Health Care Benefits Program

300 East Randolph Street | Chicago, IL 60601

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

**MyBlue Plus<sup>SM</sup>, A Blue Cross POS**

a product of Blue Cross and Blue Shield of Illinois

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

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## OUTLINE OF COVERAGE

- **READ THE POLICY CAREFULLY.** — This outline of coverage provides a brief description of the important features of the Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ THE POLICY CAREFULLY!**
- **MyBlue Plus - MyBlue Plus** provides to persons insured, coverage for major Hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services

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

### MyBlue Plus Bronze<sup>SM</sup> 903

#### MyBlue Plus

and Out-of-Hospital care, subject to any deductibles, Copayments or other limitations which may be set forth in your Policy. **To be covered under the Policy, the services you receive must be provided by or ordered by your Primary Care Physician or Woman's Principal Health Care Provider, except in certain situations such as emergencies.** To receive benefits for treatment from another Physician or Provider, you must be referred to that Provider by your Primary Care Physician or Woman's Principal Health Care Provider. The referral must be in writing and must specifically state the services that are to be rendered. Benefits will be limited to those specifically stated services.

BASIC PROVISIONS	MyBlue Plus Bronze <sup>SM</sup> 903	
	YOUR COST	
<b>Individual Deductible</b> Per individual, per calendar year. (If you have Family Coverage, each member of your family must satisfy his/her own individual deductible.)  Not all expenses will apply to this Deductible	Participating Provider	\$4,900
	Non-Participating Provider	\$15,000
<b>Family Deductible</b> If you have Family Coverage and your family has satisfied the family Deductible amount specified, it will not be necessary for anyone else in your family to meet a calendar year Deductible in the benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the calendar year Deductible before receiving benefits.  Not all expenses will apply to this Deductible	Participating Provider	\$9,800
	Non-Participating Provider	\$45,000
	Participating Provider	\$9,200

<b>Individual Out-of-Pocket Expense Limit</b> Not all costs count towards this limit	Non-Participating Provider	<b>Unlimited</b>
<b>Family Out-of-Pocket Expense Limit</b> Not all costs count towards this limit	Participating Provider	<b>\$18,400</b>
	Non-Participating Provider	<b>Unlimited</b>
<b>Inpatient Hospitals Benefits</b> Including, but not limited to Daily bed, board and general nursing care, and ancillary services (i.e., operating rooms, drugs, surgical dressings, and lab work).		
	<b>YOUR COST</b>	
<b>Inpatient Hospital Covered Services</b>	Participating Provider	\$850/stay then 50% of the Eligible Charge
	Non-Participating Provider	\$2,000/stay then 50% of the Eligible Charge
<b>Inpatient Hospital Copayment</b>	Participating Provider	\$850/stay then 50% of the Eligible Charge
	Non-Participating Provider	\$2,000/stay then 50% of the Eligible Charge
<b>Outpatient Hospital Benefits</b> Including, but not limited to Surgery, Diagnostic Services, radiation, therapy, Chemotherapy, electroconvulsive therapy, renal dialysis treatments and continuous ambulatory peritoneal dialysis treatment, coordinated home care program, pre-admission testing, partial hospitalization treatment program, Autism Spectrum Disorders, habilitative services, surgical implants, maternity services, abortion care, and urgent care.		
<b>Outpatient Hospital Covered Services</b> (except for surgical sterilization procedure)	Participating Provider	\$850/stay then 50% of the Eligible Charge
	Non-Participating Provider	\$2,000/stay then 50% of the Eligible Charge
<b>Surgical sterilization procedure</b>	Participating Provider	\$850/stay then 50% of the Eligible Charge
	Non-Participating Provider	\$2,000/stay then 50% of the Eligible Charge
<b>Outpatient Diagnostic X-Ray Services from a Participating Provider</b>	Freestanding Facility	50% of the Eligible Charge
	Hospital Setting	50% of the Eligible Charge
<b>Outpatient Diagnostic X-Ray Services from a Non-Participating Provider</b>	50% of the Eligible Charge	
<b>Outpatient Laboratory from a Participating Provider</b>	Freestanding Facility	50% of the Eligible Charge
	Hospital Setting	50% of the Eligible Charge
<b>Outpatient Laboratory Services from a Non-Participating Provider</b>	\$2,000/stay then 50% of the Eligible Charge	

<b>Outpatient Surgery from a Participating Provider</b>	Freestanding Facility	\$600/visit then 50% of the Eligible Charge
	Hospital Setting	\$600/visit then 50% of the Eligible Charge
<b>Outpatient Surgery from a Non-Participating Provider</b>	\$2,000/stay then 50% of the Eligible Charge	
<b>Certain Diagnostic Tests from a Participating Provider: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI)</b>	Freestanding Facility	50% of the Eligible Charge
	Hospital Setting	50% of the Eligible Charge
<b>Certain Diagnostic Tests from a Non-Participating Provider: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI)</b>	50% of the Eligible Charge	
<b>Urgent Care Facility visit from a Participating Provider</b>	\$60/visit	
<b>Hospital Emergency Care</b>		
	<b>YOUR COST</b>	
<b>Emergency Accident Care from either a Participating or Non-Participating Provider</b>	\$1,000/visit then 50% of the Eligible Charge	
<b>Emergency Medical Care, Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department from either a Participating or Non-Participating Provider</b>	50% of the Eligible Charge	
<b>Emergency department services that are not Emergency Accident Care, Emergency Medical Care, or Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department</b>	Participating Provider	\$1,000/visit then 50% of the Eligible Charge
	Non-Participating Provider	50% of the Eligible Charge
<b>Emergency Room Copayment</b>  (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	\$1,000/visit then 50% of the Eligible Charge	

**Physician Benefits** Surgery, anesthesia, assistant surgeon, Medical Care, treatment of illness, consultations, mammograms, Outpatient periodic health examinations, routine pediatric care, Diagnostic Services, injected medicines, amino acid-based elemental formulas, electroconvulsive therapy, radiation therapy, Chemotherapy, cancer medications, Outpatient rehabilitative therapy, Autism Spectrum Disorders , habitative services, rehabilitative services, Outpatient respiratory therapy, chiropractic and osteopathic manipulation, hearing screening, diabetes self-management training and education, pediatric vision care, dental accident care, family planning services, Outpatient contraceptive services, bone mass measurement and osteoporosis, investigational cancer treatment, Infertility treatment, mastectomy related services, maternity services, abortion care, and urgent care.

	YOUR COST	
<b>Surgical/Medical Covered Services</b>	Participating Provider	\$200/visit then 50% of the Eligible Charge
	Non-Participating Provider	50% of the Eligible Charge
<b>Outpatient office visits</b>	Participating Provider	\$45/visit
	Non-Participating Provider	50% of the Eligible Charge
<b>Outpatient Specialist office visits</b>	Participating Provider	50% of the Eligible Charge
	Non-Participating Provider	50% of the Eligible Charge
<b>Surgical sterilization procedures</b>	Participating Provider	\$850/stay then 50% of the Eligible Charge
	Non-Participating Provider	\$2,000/stay then 50% of the Eligible Charge
<b>Outpatient Mental Illness and Substance Use Disorder Office Visit (Participating Providers)</b>	50% of the Eligible Charge	
<b>Chiropractic and Osteopathic Manipulation</b>	50% of the Eligible Charge	
<b>Naprapathic Services</b>	15 visit maximum per calendar year	
<b>Emergency Accident Care from either a Participating or Non-Participating Provider</b>	\$1,000/visit then 50% of the Eligible Charge	
<b>Emergency Medical Care, Mental Illness or Substance Use Disorder services provided in a Hospital emergency department from either a Participating or Non-Participating Provider</b>	50% of the Eligible Charge	
	Participating Provider	\$1,000/visit then 50% of the Eligible Charge

<b>Emergency department services that are not Emergency Accident Care, Emergency Medical Care, Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department</b>	Non-Participating Provider	50% of the Eligible Charge
<b>Other (Miscellaneous) Covered Services</b> Blood and blood components; Ambulance Transportation, medical and surgical dressings, supplies, casts and splints, prosthetic devices, orthotic devices and durable medical equipment.		50% of the Eligible Charge
<b>Preventive Care Services from a Participating Provider</b> Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, Deductible, Copayment or dollar maximum (to be implemented in the quantities and within the time period allowed under the applicable law or regulatory guidance): 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 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 additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, 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).		None
<b>Preventive Care Services from a Non-Participating Provider</b>		50% of the Eligible Charge
<b>Virtual Visits</b> Benefits will be provided for Covered Services described in the Policy for the diagnosis and treatment of non-emergency medical and behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment	Primary Care	\$45/visit
	Specialist	50% of the Eligible Charge
	Urgent Care	\$60/visit

can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit.		
<b>Telehealth and Telemedicine Services</b>	50% of the Eligible Charge	
<b>Non-Maintenance Drugs</b>	Participating Provider	50% of the Eligible Charge
	Non-Participating Provider	50% of the Eligible Charge
<b>Hearing Aid Benefits</b>		
Benefit Period	24 months	
Benefit maximum	None	
Benefit payment level	50% of the Maximum Allowance	
Number of Hearing Aids per ear, each Benefit Period	One	

\*The calendar year Deductible, Copayment amount and Out-of-Pocket expense limit amounts may be subject to change or increase as permitted by applicable law or regulatory guidance.

## OUTPATIENT PRESCRIPTION DRUG PROGRAM

**Please refer to the Outpatient Prescription Drug Program Section of the Policy for additional information regarding how payment is determined. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives.**

Benefits are available for contraceptive drugs and products shown on the Contraceptive Coverage List and will not be subject to any deductible, Coinsurance Amount, and/or Copayment Amount when received from a Participating Pharmacy Provider. Your share of the cost for all other contraceptive drugs and products will be provided as shown below.

If you or your Provider request a Brand Name Drug when a Generic Drug is available, you will pay the applicable Copayment Amount and/or Coinsurance based on current tier of Brand Name Drug Plus the difference between the allowable amount of the Brand Name Drug and the allowable amount of the Generic Drug, except as otherwise provided in the Policy. Any "differences" between the cost of the Generic Drug and the cost of the Brand Name Drug will apply to the deductible or out-of-pocket maximum. The applicable cost-sharing (by tier) and the cost difference between the generic and brand will never exceed the overall actual price of the drug.

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

The amount you may pay for a twin-pack of Medically Necessary epinephrine injectors, regardless of type, shall not exceed \$60, when obtained from a Preferred Participating or Participating Pharmacy, after your program deductible has been met.

<b>30-Day Supply Outpatient Prescription Drug Program</b>	
<b>Tier 1</b>	0% of the Eligible Charge per prescription None
<b>Tier 2</b>	10% of the Eligible Charge per prescription
<b>Tier 3</b>	20% of the Eligible Charge per prescription
<b>Tier 4</b>	35% of the Eligible Charge per prescription
<b>Tier 5</b>	45% of the Eligible Charge per prescription
<b>Tier 6</b>	50% of the Eligible Charge per prescription
<b>90-Day Supply Outpatient Prescription Drug Program</b>	
<b>Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed</b>	
<b>Tier 1</b>	0% of the Eligible Charge per prescription None
<b>Tier 2</b>	10% of the Eligible Charge per prescription
<b>Tier 3</b>	20% of the Eligible Charge per prescription
<b>Tier 4</b>	35% of the Eligible Charge per prescription
<b>DEPENDENT LIMITING AGE</b>	
<b>Limiting Age for Dependent Children</b> (regardless of presence or absence of child's financial dependency, residency, student status, employment)	26

status, marital status, eligibility for other coverage or any combination of these factors)

*(In addition, enrolled unmarried children will be covered up to the age of 30 if they live within the service area of the Plan network for the 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.)*

**Schedule of Pediatric Vision Coverage  
For Covered Persons Under Age 19**

<b>Pediatric Vision Care Services</b>	<b>Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider</b> (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	<b>Allowance when Covered Services are received from a Non-Participating Vision Provider</b> (Maximum amount payable under the Policy, not to exceed the retail costs)**
<b>Exam</b> (with dilation as necessary; routine eye examinations do not include professional services for contact lenses):	No Copayment	Up to \$30
<b>Frames:</b>		
"Provider-Designated" frame Frames covered under the Policy are limited to the Provider-designated frames which include a selection of frame sizes (including adult sizes) for children up to age 19. The Participating Vision Provider will show you the selection of frames covered under the Policy. If you select a frame that is not included in the Provider-designated frames covered under the Policy, you are responsible for the difference in cost between the Participating Vision Provider reimbursement amount for covered frames and the retail price of the frame selected. If frames are provided by a Non-Participating Vision Provider, benefits are limited to the amount shown above. Any amount 1) paid to the Non-Participating Vision Provider for the difference in cost of a non-Provider-designated frame or 2) that exceeds the maximum amount payable for a Non-Participating Vision Provider supplied frame will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket expense limit/Out-of-Pocket Coinsurance maximum.	No Copayment	Up to \$75
Non-Provider - Designated Frames	No copay up to \$150, 20% discount after \$150 and member responsible.	Upto \$75
<b>Frequency:</b>  Examination, Lenses or Contact Lenses Frame		
Once every 12-month benefit period  Once every 12-month benefit period		
<b>Standard Plastic, Glass or Polycarbonate Spectacle Lenses:</b>		
Single Vision	No Copayment	Up to \$25
Bifocal	No Copayment	Up to \$40
Trifocal	No Copayment	Up to \$55

<b>Pediatric Vision Care Services</b>	<b>Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider</b> (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	<b>Allowance when Covered Services are received from a Non-Participating Vision Provider</b> (Maximum amount payable under the Policy, not to exceed the retail costs)**
Lenticular	No Copayment	Up to \$55
Standard Progressive Lens	No Copayment	Up to \$55
<b>Lens Options (add to lens costs above):</b> UV Treatment	No Copayment	Up to \$12
Standard Plastic Scratch Coating	No Copayment	Up to \$12
Standard Polycarbonate -	No Copayment	Up to \$32
Photocromic/ Transitions Plastic	No Copayment	Up to \$57
<b>Contact Lenses:</b> (Contact lens allowance includes materials only)	100% coverage for Provider-designated contact lenses	Up to \$150
Elective -		
Extended Wear Disposables	Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	Up to \$150
Daily Wear / Disposable	Up to 3 months supply of daily disposable, single vision spherical contact lenses	Up to \$150
Conventional	1 pair from selection of Provider-designated contact lenses	Up to \$210
Medically Necessary contact lenses – Preauthorization is required to be considered for benefits (see details below)		

<b>Pediatric Vision Care Services</b>	<b>Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider</b> (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	<b>Allowance when Covered Services are received from a Non-Participating Vision Provider</b> (Maximum amount payable under the Policy, not to exceed the retail costs)**
Contact lenses covered under the Policy are limited to the Provider-designated contact lenses. The Participating Vision Provider will inform you of the contact lens selection covered under the Policy. If you select a lens that is not included in the pediatric lens selection covered under the Policy, you are responsible for the difference in cost between the Participating Vision Provider reimbursement amount for covered contact lenses and the retail price of the contact lenses selected. Any amount 1) paid to the Participating Vision Provider for the difference in cost of a non-Provider-designated contact lens or 2) that exceeds the maximum amount payable for Non-Participating Vision Provider supplied contact lenses will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket expense limit/Out-of-Pocket coinsurance maximum.		
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.		
<b>Value-added features:</b> <b>Laser vision correction:</b> You will receive a discount for traditional LASIK and custom LASIK from Participating Physicians and contracted laser centers. You must obtain Preauthorization for this service in order to receive coverage. Prices/discounts may vary by state and are subject to change without notice.		

## **GUARANTEED RENEWABILITY \***

Coverage under this Policy will be terminated for nonpayment of premiums as described below. Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (herein called "Blue Cross and Blue Shield") may terminate or refuse to renew this Policy for any of the following reasons:

1. If every Policy that bears this Policy form number, is not renewed or if Blue Cross and Blue Shield ceases to offer a particular type of coverage in the individual market. If this should occur:
  - a. Blue Cross and Blue Shield will give you at least 90 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
  - b. You may convert to any other individual Policy offered to the individual market.
  - c. If Blue Cross and Blue Shield should terminate or refuse to terminate this Policy, it must do so uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
2. If Blue Cross and Blue Shield discontinues all health care coverage and does not renew all health insurance Policies it issues or delivers for issuance in the individual market in the state of Illinois. If this should occur, Blue Cross and Blue Shield will give you at least 180 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
3. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
4. You no longer reside, live or work in the Blue Cross and Blue Shield of Illinois' network service area.
5. Failure to pay your premium in accordance with the terms of the Policy. When you renew Blue Cross and Blue Shield coverage or reenroll by selecting a new product (as defined by applicable law), you will need to be current on your premium payments. Any past due premium payments for coverage we provided must be paid no later than your Coverage Date for the new year, in addition to initial premium charges. New coverage will not be effective until all such payments are made.
6. Other reasons described in this Policy.

\* Blue Cross and Blue Shield will not terminate or refuse to renew this Policy because of the condition of your health.

## **EXCLUSIONS AND LIMITATIONS:**

Hospitalization, services and supplies which are not Medically Necessary.

Services or supplies that are not specifically mentioned in the Policy.

Services or supplies provided outside of Illinois, with the following exceptions: (1) emergency or urgent care, (2) services or supplies received after the Member is granted an approved service area waiver, (3) services or supplies received from Participating Providers that do not require a service area waiver. For more information about how to request a service area waiver, contact Customer Service. To identify Participating Providers outside of Illinois that do not require a service area waiver, consult the current online provider directory.

Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a Claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, (except in the case of Medicare), except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 §1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

Services or supplies that do not meet accepted standards of medical and/or dental practice.

Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under the Policy for a) Routine Patient Costs associated with Experimental/Investigational cancer treatment, if you are a qualified individual participating in a qualified clinical cancer trial, if those services or

Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions.).

Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

Special braces, specialized equipment, appliances, or ambulatory apparatus, except as specifically mentioned in the Policy.

Blood derivatives which are not classified as drugs in the official formularies.

Eyeglasses, contact lenses or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye which are not Medically Necessary, except as specifically mentioned in the Policy. This exclusion is not applicable to children as described in the Policy.

Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

Immunizations, unless otherwise specified in the Policy.

Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in the Policy.

Acupuncture, whether for medical or anesthesia purposes.

Maintenance Care.

Hearing Aids, except for bone anchored Hearing Aids (osseointegrated auditory implants), or examinations for the prescription or fitting of Hearing Aids, unless otherwise

supplies would otherwise be covered under the Policy if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

Custodial Care Service.

Long Term Care Service.

Respite Care Service, except as specifically mentioned under the Hospice Care Program section of the Policy.

Inpatient Private Duty Nursing.

Diagnostic Service as part of determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Experimental/Investigational, unless otherwise specified in the Policy.

Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, for the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

Wigs (also referred to as cranial prostheses), unless otherwise specified in the Policy.

Services and supplies rendered or provided for human organ or tissue transplants other than those specifically mentioned in the Policy.

Reversals of vasectomies.

Any related services to a non-Covered Service except for routine patient care for participants in an Approved Clinical Trial.

Any drugs and medicines, except as may be provided under Outpatient Prescription Drug Program Benefits, that are:

- Dispensed by a Pharmacy and received by you while covered under the Policy;
- Dispensed in a Provider's office or during confinement in a Hospital or other acute care institution or facility and received by you for use on an Outpatient basis;
- Over-the-counter drugs and medicines; or drugs for which no charge is made;
- Prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.

specified in the Policy. This exclusion is not applicable to children as described in the Policy.

Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in the Policy.

Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.

Notwithstanding any provision in the Policy to the contrary, any services and/or supplies provided to you outside the United States, unless you receive Emergency Accident Care or Emergency Medical Care.

- Benefits will not be provided for any self-administered drugs dispensed by a Physician.

- Services and supplies from more than one Provider on the same day(s) to the extent benefits are duplicated.

Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes, except for Covered Services provided by appropriate Providers as defined in this Policy. Any of the following applied behavior analysis (ABA) related services;

- Services with a primary diagnosis that is not Autism Spectrum Disorder;
- Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of "Qualified ABA Provider" in the DEFINITIONS SECTION of this Policy;
- Activities primarily of an educational nature;
- Shadow or companion services; or
- Any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

## SCHEDULE PAGE

**\*\*Your benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire Policy. All capitalized terms have the meanings set forth in the Policy.**

BASIC PROVISIONS		MyBlue Plus Bronze <sup>SM</sup> 903	
		YOUR COST	
<b>Individual Deductible</b> Per individual, per calendar year. (If you have Family Coverage, each member of your family must satisfy his/her own individual deductible.)  Not all expenses will apply to this Deductible	Participating Provider	\$4,900	
	Non-Participating Provider	\$15,000	
<b>Family Deductible</b> If you have Family Coverage and your family has satisfied the family Deductible amount specified, it will not be necessary for anyone else in your family to meet a calendar year Deductible in the benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the calendar year Deductible before receiving benefits.  Not all expenses will apply to this Deductible	Participating Provider	\$9,800	
	Non-Participating Provider	\$45,000	
<b>Individual Out-of-Pocket Expense Limit</b>  Not all costs count towards this limit	Participating Provider	\$9,200	
	Non-Participating Provider	Unlimited	
<b>Family Out-of-Pocket Expense Limit</b>  Not all costs count towards this limit	Participating Provider	\$18,400	
	Non-Participating Provider	Unlimited	
<b>Inpatient Hospitals Benefits</b> Including, but not limited to Daily bed, board and general nursing care, and ancillary services (i.e., operating rooms, drugs, surgical dressings, and lab work).			
		YOUR COST	
<b>Inpatient Hospital Covered Services</b>	Participating Provider	\$850/stay then 50% of the Eligible Charge	
	Non-Participating Provider	\$2,000/stay then 50% of the Eligible Charge	
<b>Inpatient Hospital Copayment</b>	Participating Provider	\$850/stay then 50% of the Eligible Charge	
	Non-Participating Provider	\$2,000/stay then 50% of the Eligible Charge	

<b>Outpatient Hospital Benefits</b> Including, but not limited to Surgery, Diagnostic Services, radiation, therapy, Chemotherapy, electroconvulsive therapy, renal dialysis treatments and continuous ambulatory peritoneal dialysis treatment, coordinated home care program, pre-admission testing, partial hospitalization treatment program, Autism Spectrum Disorders, habilitative services, surgical implants, maternity services, abortion care, and urgent care.		
<b>Outpatient Hospital Covered Services</b> (except for surgical sterilization procedure)	Participating Provider	\$850/stay then 50% of the Eligible Charge
	Non-Participating Provider	\$2,000/stay then 50% of the Eligible Charge
<b>Surgical sterilization procedure</b>	Participating Provider	\$850/stay then 50% of the Eligible Charge
	Non-Participating Provider	\$2,000/stay then 50% of the Eligible Charge
<b>Outpatient Diagnostic X-Ray Services from a Participating Provider</b>	Freestanding Facility	50% of the Eligible Charge
	Hospital Setting	50% of the Eligible Charge
<b>Outpatient Diagnostic X-Ray Services from a Non-Participating Provider</b>	50% of the Eligible Charge	
<b>Outpatient Laboratory from a Participating Provider</b>	Freestanding Facility	50% of the Eligible Charge
	Hospital Setting	50% of the Eligible Charge
<b>Outpatient Laboratory Services from a Non-Participating Provider</b>	\$2,000/stay then 50% of the Eligible Charge	
<b>Outpatient Surgery from a Participating Provider</b>	Freestanding Facility	\$600/visit then 50% of the Eligible Charge
	Hospital Setting	\$600/visit then 50% of the Eligible Charge
<b>Outpatient Surgery from a Non-Participating Provider</b>	\$2,000/stay then 50% of the Eligible Charge	
<b>Certain Diagnostic Tests from a Participating Provider: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI)</b>	Freestanding Facility	50% of the Eligible Charge
	Hospital Setting	50% of the Eligible Charge
<b>Certain Diagnostic Tests from a Non-Participating Provider: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI)</b>	50% of the Eligible Charge	

<b>Urgent Care Facility visit from a Participating Provider</b>	\$60/visit	
<b>Hospital Emergency Care</b>		
	<b>YOUR COST</b>	
<b>Emergency Accident Care from either a Participating or Non-Participating Provider</b>	\$1,000/visit then 50% of the Eligible Charge	
<b>Emergency Medical Care, Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department from either a Participating or Non-Participating Provider</b>	50% of the Eligible Charge	
	Participating Provider	\$1,000/visit then 50% of the Eligible Charge
<b>Emergency department services that are not Emergency Accident Care, Emergency Medical Care, or Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department</b>	Non-Participating Provider	50% of the Eligible Charge
	\$1,000/visit then 50% of the Eligible Charge	
<b>Emergency Room Copayment</b>  (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	\$1,000/visit then 50% of the Eligible Charge	
<b>Physician Benefits</b> Surgery, anesthesia, assistant surgeon, Medical Care, treatment of illness, consultations, mammograms, Outpatient periodic health examinations, routine pediatric care, Diagnostic Services, injected medicines, amino acid-based elemental formulas, electroconvulsive therapy, radiation therapy, Chemotherapy, cancer medications, Outpatient rehabilitative therapy, Autism Spectrum Disorders , habilitative services, rehabilitative services, Outpatient respiratory therapy, chiropractic and osteopathic manipulation, hearing screening, diabetes self-management training and education, pediatric vision care, dental accident care, family planning services, Outpatient contraceptive services, bone mass measurement and osteoporosis, investigational cancer treatment, Infertility treatment, mastectomy related services, maternity services, abortion care, and urgent care.		
	<b>YOUR COST</b>	
<b>Surgical/Medical Covered Services</b>	Participating Provider	\$200/visit then 50% of the Eligible Charge
	Non-Participating Provider	50% of the Eligible Charge
<b>Outpatient office visits</b>	Participating Provider	\$45/visit
	Non-Participating Provider	50% of the Eligible Charge
	Participating Provider	50% of the Eligible Charge

<b>Outpatient Specialist office visits</b>	Non-Participating Provider	50% of the Eligible Charge
<b>Surgical sterilization procedures</b>	Participating Provider	\$850/stay then 50% of the Eligible Charge
	Non-Participating Provider	\$2,000/stay then 50% of the Eligible Charge
<b>Outpatient Mental Illness and Substance Use Disorder Office Visit (Participating Providers)</b>	50% of the Eligible Charge	
<b>Chiropractic and Osteopathic Manipulation</b>	50% of the Eligible Charge	
<b>Naprapathic Services</b>	15 visit maximum per calendar year	
<b>Emergency Accident Care from either a Participating or Non-Participating Provider</b>	\$1,000/visit then 50% of the Eligible Charge	
<b>Emergency Medical Care, Mental Illness or Substance Use Disorder services provided in a Hospital emergency department from either a Participating or Non-Participating Provider</b>	50% of the Eligible Charge	
<b>Emergency department services that are not Emergency Accident Care, Emergency Medical Care, Mental Illness, or Substance Use Disorder services provided in a Hospital emergency department</b>	Participating Provider	\$1,000/visit then 50% of the Eligible Charge
	Non-Participating Provider	50% of the Eligible Charge
<b>Other (Miscellaneous) Covered Services</b> Blood and blood components; Ambulance Transportation, medical and surgical dressings, supplies, casts and splints, prosthetic devices, orthotic devices and durable medical equipment.	50% of the Eligible Charge	
<b>Preventive Care Services from a Participating Provider</b> Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, Deductible, Copayment or dollar maximum (to be implemented in the quantities and within the time period allowed under the applicable law or regulatory guidance): Evidence-based items or services that have in effect a rating of "A" or "B"	None	

<p>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 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 additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, 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).</p>							
<p><b>Preventive Care Services from a Non-Participating Provider</b></p>	<p>50% of the Eligible Charge</p>						
<p><b>Virtual Visits</b> Benefits will be provided for Covered Services described in the Policy for the diagnosis and treatment of non-emergency medical and behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit.</p>	<table border="1"> <tr> <td data-bbox="690 879 976 925">Primary Care</td><td data-bbox="976 879 1538 925">\$45/visit</td></tr> <tr> <td data-bbox="690 936 976 982">Specialist</td><td data-bbox="976 936 1538 982">50% of the Eligible Charge</td></tr> <tr> <td data-bbox="690 993 976 1039">Urgent Care</td><td data-bbox="976 993 1538 1039">\$60/visit</td></tr> </table>	Primary Care	\$45/visit	Specialist	50% of the Eligible Charge	Urgent Care	\$60/visit
Primary Care	\$45/visit						
Specialist	50% of the Eligible Charge						
Urgent Care	\$60/visit						
<p><b>Telehealth and Telemedicine Services</b></p>	<p>50% of the Eligible Charge</p>						
<p><b>Non-Maintenance Drugs</b></p>	<table border="1"> <tr> <td data-bbox="690 1343 976 1390">Participating Provider</td><td data-bbox="976 1343 1538 1390">50% of the Eligible Charge</td></tr> <tr> <td data-bbox="690 1400 976 1447">Non-Participating Provider</td><td data-bbox="976 1400 1538 1447">50% of the Eligible Charge</td></tr> </table>	Participating Provider	50% of the Eligible Charge	Non-Participating Provider	50% of the Eligible Charge		
Participating Provider	50% of the Eligible Charge						
Non-Participating Provider	50% of the Eligible Charge						
<p><b>Hearing Aid Benefits</b></p>							
<p>Benefit Period</p>	<p>24 months</p>						
<p>Benefit maximum</p>	<p>None</p>						
<p>Benefit payment level</p>	<p>50% of the Maximum Allowance</p>						

Number of Hearing Aids per ear, each Benefit Period	One
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\*The calendar year Deductible, Copayment amount and Out-of-Pocket expense limit amounts may be subject to change or increase as permitted by applicable law or regulatory guidance.

## **OUTPATIENT PRESCRIPTION DRUG PROGRAM**

**Please refer to the Outpatient Prescription Drug Program Section of the Policy for additional information regarding how payment is determined. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives.**

Benefits are available for contraceptive drugs and products shown on the Contraceptive Coverage List and will not be subject to any deductible, Coinsurance Amount, and/or Copayment Amount when received from a Participating Pharmacy Provider. Your share of the cost for all other contraceptive drugs and products will be provided as shown below.

If you or your Provider request a Brand Name Drug when a Generic Drug is available, you will pay the applicable Copayment Amount and/or Coinsurance based on current tier of Brand Name Drug Plus the difference between the allowable amount of the Brand Name Drug and the allowable amount of the Generic Drug, except as otherwise provided in the Policy. Any "differences" between the cost of the Generic Drug and the cost of the Brand Name Drug will apply to the deductible or out-of-pocket maximum. The applicable cost-sharing (by tier) and the cost difference between the generic and brand will never exceed the overall actual price of the drug.

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

The amount you may pay for a twin-pack of Medically Necessary epinephrine injectors, regardless of type, shall not exceed \$60, when obtained from a Preferred Participating or Participating Pharmacy, after your program deductible has been met.

<b>30-Day Supply Outpatient Prescription Drug Program</b>	
<b>Tier 1</b>	0% of the Eligible Charge per prescription None
<b>Tier 2</b>	10% of the Eligible Charge per prescription
<b>Tier 3</b>	20% of the Eligible Charge per prescription
<b>Tier 4</b>	35% of the Eligible Charge per prescription
<b>Tier 5</b>	45% of the Eligible Charge per prescription
<b>Tier 6</b>	50% of the Eligible Charge per prescription
<b>90-Day Supply Outpatient Prescription Drug Program</b>	
<b>Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed</b>	
<b>Tier 1</b>	0% of the Eligible Charge per prescription None
<b>Tier 2</b>	10% of the Eligible Charge per prescription
<b>Tier 3</b>	20% of the Eligible Charge per prescription
<b>Tier 4</b>	35% of the Eligible Charge per prescription

## DEPENDENT LIMITING AGE

### **Limiting Age for Dependent Children**

(regardless of presence or absence of child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of these factors)

*(In addition, enrolled unmarried children will be covered up to the age of 30 if they live within the service area of the Plan network for the 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.)*

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**Schedule of Pediatric Vision Coverage  
For Covered Persons Under Age 19**

<b>Pediatric Vision Care Services</b>	<b>Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider</b> (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	<b>Allowance when Covered Services are received from a Non-Participating Vision Provider</b> (Maximum amount payable under the Policy, not to exceed the retail costs)**
<b>Exam</b> (with dilation as necessary; routine eye examinations do not include professional services for contact lenses):	No Copayment	Up to \$30
<b>Frames:</b>		
"Provider-Designated" frame Frames covered under the Policy are limited to the Provider-designated frames which include a selection of frame sizes (including adult sizes) for children up to age 19. The Participating Vision Provider will show you the selection of frames covered under the Policy. If you select a frame that is not included in the Provider-designated frames covered under the Policy, you are responsible for the difference in cost between the Participating Vision Provider reimbursement amount for covered frames and the retail price of the frame selected. If frames are provided by a Non-Participating Vision Provider, benefits are limited to the amount shown above. Any amount 1) paid to the Non-Participating Vision Provider for the difference in cost of a non-Provider-designated frame or 2) that exceeds the maximum amount payable for a Non-Participating Vision Provider supplied frame will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket expense limit/Out-of-Pocket Coinsurance maximum.	No Copayment	Up to \$75
Non-Provider - Designated Frames	No copay up to \$150, 20% discount after \$150 and member responsible.	Upto \$75
<b>Frequency:</b>  Examination, Lenses or Contact Lenses Frame		
Once every 12-month benefit period  Once every 12-month benefit period		
<b>Standard Plastic, Glass or Polycarbonate Spectacle Lenses:</b>		
Single Vision	No Copayment	Up to \$25
Bifocal	No Copayment	Up to \$40
Trifocal	No Copayment	Up to \$55

Pediatric Vision Care Services	Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider  (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	Allowance when Covered Services are received from a Non-Participating Vision Provider  (Maximum amount payable under the Policy, not to exceed the retail costs)**
Lenticular	No Copayment	Up to \$55
Standard Progressive Lens	No Copayment	Up to \$55
<b>Lens Options (add to lens costs above):</b> UV Treatment	No Copayment	Up to \$12
Standard Plastic Scratch Coating	No Copayment	Up to \$12
Standard Polycarbonate -	No Copayment	Up to \$32
Photocromic/ Transitions Plastic	No Copayment	Up to \$57
<b>Contact Lenses:</b> (Contact lens allowance includes materials only)	100% coverage for Provider-designated contact lenses	Up to \$150
Elective -		
Extended Wear Disposables	Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	Up to \$150
Daily Wear / Disposable	Up to 3 months supply of daily disposable, single vision spherical contact lenses	Up to \$150
Conventional	1 pair from selection of Provider-designated contact lenses	Up to \$210
Medically Necessary contact lenses – Preauthorization is required to be considered for benefits (see details below)		

<b>Pediatric Vision Care Services</b>	<b>Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider</b> (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	<b>Allowance when Covered Services are received from a Non-Participating Vision Provider</b> (Maximum amount payable under the Policy, not to exceed the retail costs)**
Contact lenses covered under the Policy are limited to the Provider-designated contact lenses. The Participating Vision Provider will inform you of the contact lens selection covered under the Policy. If you select a lens that is not included in the pediatric lens selection covered under the Policy, you are responsible for the difference in cost between the Participating Vision Provider reimbursement amount for covered contact lenses and the retail price of the contact lenses selected. Any amount 1) paid to the Participating Vision Provider for the difference in cost of a non-Provider-designated contact lens or 2) that exceeds the maximum amount payable for Non-Participating Vision Provider supplied contact lenses will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket expense limit/Out-of-Pocket coinsurance maximum.		
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.		
<b>Value-added features:</b> <b>Laser vision correction:</b> You will receive a discount for traditional LASIK and custom LASIK from Participating Physicians and contracted laser centers. You must obtain Preauthorization for this service in order to receive coverage. Prices/discounts may vary by state and are subject to change without notice.		

**Schedule of Pediatric Vision Coverage  
For Covered Persons Under Age 19**

<b>Pediatric Vision Care Services</b>	<b>Covered person Cost or Discount when Covered Services are received from a Participating Vision Care Provider</b>  (When a fixed-dollar Copayment is due from the member, the remainder is payable by Blue Cross and Blue Shield up to the covered charge*)	<b>Allowance when Covered Services are received from a Non-Participating Vision Care Provider</b>
<b>Exam</b> (with dilation as necessary; routine eye examinations do not include professional services for Contact Lenses)	No Copayment	Not covered
<b>Frames:</b>		
"Provider-designated" Frames	No Copayment	Not covered
Frames covered under this Policy are limited to the Provider-designated frames which include a selection of frame sizes (including adult sizes) for children up to age 19. The Participating Vision Provider will show you the selection of frames covered under the 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 Participating Vision Provider reimbursement amount for covered frames and the retail price of the frame selected.	No copay up to \$150, 20% discount after \$150 and member responsible.	Not covered
Non-Provider-designated Frames	No Copayment	Not covered
<b>Frequency:</b> Examination, Lenses or Contact Lenses	Once every 12-month Benefit Period	Not covered
Frame	Once every 12-month Benefit Period	Not covered
<b>Standard Plastic, Glass or Polycarbonate Spectacle Lenses:</b>  Single Vision Bifocal Trifocal Lenticular Standard Progressive Lens	No Copayment No Copayment No Copayment No Copayment No Copayment	Not covered
<b>Lens Options (add to lens costs above):</b>  UV Treatment Standard Plastic Scratch Coating Standard Polycarbonate - Photochromatic / Transitions Plastic	No Copayment No Copayment No Copayment No Copayment	Not covered

<b>Contact Lenses:</b> (Contact lens allowance includes materials only)	100% coverage for Provider-designated contact lenses	Not covered
Elective -		
Extended Wear Disposables	Up to 6 months supply of monthly or 2-week disposable, single vision spherical or toric contact lenses	Not covered
Daily Wear / Disposable	Up to 3 months supply of daily disposable, single vision spherical contact lenses	Not covered
Conventional	1 pair from selection of Provider-designated contact lenses	Not covered
Medically Necessary contact lenses – prior authorization is required	No Copayment	Not covered

### **Additional Benefits**

#### **Value-added features:**

**Laser vision correction:** You will receive a discount for traditional LASIK and custom LASIK from participating Physicians and affiliated laser centers. You must obtain Preauthorization for this service. Prices/discounts may vary by state and are subject to change without notice.

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

**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, posttraumatic disorders, irregular astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eye wear. Participating Providers will obtain the necessary preauthorization for these services.

**Low Vision:** Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for our members with low vision.

**Warranty:** Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Please ask your Provider for details of the warranty that is available to you.

\* The “covered charge” is the rate negotiated with Participating Providers for a particular Covered Service.

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

VISIT EYEMED'S WEBSITE AT **WWW.EYEMED.COM** AND USE THE FIND A PROVIDER LINK (CHOOSE THE SELECT NETWORK FOR YOUR SEARCH), OR CALL 1-844-684-2254.

A message from

## BLUE CROSS AND BLUE SHIELD

This Policy describes the MyBlue Plus POS health care benefits that will be provided to you by 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. The *Definition Section* will explain the meaning of many of the terms used in this Policy. All terms used in this Policy, when defined in the *Definitions Section*, begin with a capital letter. Whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

MyBlue Plus POS is a point of service product that allows a Member the choice of receiving services from providers in the MyBlue Plus POS<sup>SM</sup> Provider Network, or the Blue Cross and Blue Shield of Illinois provider network or from nonparticipating providers. The highest level of Benefits will be for services provided by a MyBlue Plus POS network provider.

Any reference to "applicable law" will include applicable laws and rules, including but not limited to statutes, ordinances, administrative decisions and regulations.

We suggest that you read this entire Policy very carefully. We hope that any questions that you might have about your coverage will be answered here.

**This Policy is currently certified as a Qualified Health Plan.**

**THIS POLICY REPLACES ANY PREVIOUS POLICIES THAT MAY HAVE BEEN ISSUED TO YOU BY BLUE CROSS AND BLUE SHIELD.**

If you have any questions once you have read this Policy, please call your local Blue Cross and Blue Shield office. It is important to all of us that you understand the protection this coverage gives you. Should you have any questions regarding your eligibility under this Policy, please contact your local Blue Cross and Blue Shield office.

Welcome to Blue Cross and Blue Shield! We are very happy to have you as a member and pledge you our best service.

Sincerely,



Stephen Harris  
President Illinois Division  
Blue Cross and Blue Shield of Illinois

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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

## **RIGHT TO EXAMINE THIS POLICY**

You have the right to examine this Policy for a 10-day period after receiving it. If, for any reason, you are not satisfied with the health care benefit program described in this Policy, you may return the Policy and your identification card(s) to Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, (herein called "Blue Cross and Blue Shield of Illinois," "Blue Cross and Blue Shield" and/or "BCBSIL") and void your coverage. Any premium that you had paid to Blue Cross and Blue Shield will be refunded to you provided that you do not receive any services or have any Claims paid under this Policy before the end of the 10-day period.

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

YOU CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN NON-EMERGENCY SITUATIONS. Except in limited situations governed by the federal No Surprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), Non-Participating Providers furnishing non-emergency services may bill members for any amount up to the billed charge after the Plan has paid its portion of the bill. If you elect to use a Non-Participating Provider, Plan benefit payments will be determined according to your Policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Policy. Participating Providers have agreed to ONLY bill members the cost-sharing amounts. You may obtain further information about the participating status of Professional Providers and information on out-of-pocket expenses by calling the toll-free telephone number on your Identification Card.

## **GUARANTEED RENEWABILITY**

Coverage under this Policy will be terminated for nonpayment of premiums as described below. Blue Cross and Blue Shield of Illinois may terminate or refuse to renew this Policy for any of the following reasons:

1. If every Policy that bears this Policy form number, is not renewed or if Blue Cross and Blue Shield ceases to offer a particular type of coverage in the individual market. If this should occur:
  - a. Blue Cross and Blue Shield will give you at least 90 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
  - b. You may convert to any other individual Policy offered to the individual market.
  - c. If Blue Cross and Blue Shield should terminate or refuse to terminate this Policy, it must do so uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
2. If Blue Cross and Blue Shield discontinues all health care coverage and does not renew all health insurance Policies, it issues or delivers for issuance in the individual market in the State of Illinois. If this should occur, Blue Cross and Blue Shield will give you at least 180 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
3. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
4. You no longer reside, live or work in the Blue Cross and Blue Shield of Illinois' Network Service Area.
5. Failure to pay your premium in accordance with the terms of the Policy. When you renew Blue Cross and Blue Shield coverage or reenroll by selecting a new product (as defined by applicable law), you will need to be current on your premium payments. Any past due premium payments for coverage we provided must be paid no later than your Coverage Date for the new year, in addition to initial premium charges. New coverage will not be effective until all such payments are made.
6. Other reasons described in this Policy.

Blue Cross and Blue Shield will not terminate or refuse to renew this Policy because of the condition of your health.

#### **NOTICE OF ANNUAL MEETING**

You are hereby notified that you are a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and you are entitled to vote in person, or by proxy, at all meetings of Members of Blue Cross and Blue Shield. The annual meeting is scheduled to be held at our principal office at 300 East Randolph, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The term "Member" as used above refers only to the person to whom this Policy has been issued, the Enrollee. Under Family Coverage, the term "Member" does not include any person other than the Enrollee unless such person is acting upon the Enrollee's behalf.

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.

#### **YOUR SCHEDULE PAGE**

A Schedule Page has been inserted into and is part of this Policy. The Schedule Page contains specific information about your coverage including, but not limited to:

1. The amount of your deductible(s), and/or Copayment(s), and/or Coinsurance amount; and
2. The Hospital and Physician benefit payment levels.

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

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## **ELIGIBILITY AND PREMIUM INFORMATION**

Subject to the other terms and conditions of this Policy, the benefits described in this Policy will be provided to persons who:

1. Have applied for and been confirmed as eligible for this coverage as determined by Blue Cross and Blue Shield;
2. Have received a Blue Cross and Blue Shield identification card; and
3. Live within the Blue Cross and Blue Shield's service area (Contact customer service at the number shown on your identification card for information regarding the service area); and
4. Reside, live or work in the geographic "Network Service Area" designated by Blue Cross and Blue Shield. You may call customer service at the number shown on your identification card to determine if you are in the Network Service Area or log on to Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com).

## **YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD**

You will receive an identification card from Blue Cross and Blue Shield. Your identification card contains your identification number. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, contact customer service or go to the Blue Cross and Blue Shield website at [www.bcbsil.com](http://www.bcbsil.com) and get a temporary card online. Always carry your identification card with you.

## **RESCISSON OF COVERAGE**

Any act, practice, or omission that constitutes fraud, or any intentional misrepresentation made by or on behalf of anyone seeking coverage under this Policy, may result in the cancellation of your coverage (and/or your dependent(s) coverage) retroactive to the effective date, subject to 30 days prior notification. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates. In the event of such 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. At any time when Blue Cross and Blue Shield is entitled to rescind coverage already in force, or is otherwise permitted to make retroactive changes to this Policy, Blue Cross and Blue Shield may make an offer to reform this Policy already in force and/or change the rating category/level. In the event of reformation, this Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application. You have 180 days to appeal a Rescission or reformation of coverage. Please refer to the section *How To File A Claim* for information about your appeal rights concerning Rescission and/or reformation.

## **INDIVIDUAL COVERAGE**

If you have Individual Coverage, only your own health care expenses are covered, not the health care expenses of other members of your family including newborns.

## **FAMILY COVERAGE**

If you have Family Coverage, your health care expenses and those of your enrolled spouse and your (or your spouse's) enrolled children who are under age 26 will be covered. All of the provisions of this Policy that pertain to a spouse also apply to a party of a Civil Union. A Domestic Partner and his/her children who are under age 26 are also eligible dependents. All of the provisions of this Policy that pertain to a spouse also apply to a Domestic Partner.

"Child(ren)" used hereafter in this Policy, means a natural child(ren), a stepchild(ren), an adopted child(ren), a foster child(ren), a child(ren) of your Domestic Partner, a child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, a child of your child, a grandchild(ren), a child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors.

In addition, enrolled unmarried children will be covered up to the age of 30 if they:

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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

1. Live within the Blue Cross and Blue Shield's service area; and
2. Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
3. Have received a release or discharge other than a dishonorable discharge.

Coverage for enrolled unmarried college students will continue to be provided for up to 12 months if he/she takes a medical leave of absence or reduces his/her course load to part - time status because of a serious illness or injury. Such continuation of coverage because of a serious illness or injury will terminate 12 months after notice of the illness or injury.

Newborn children will be covered from the moment of birth. Please notify Blue Cross and Blue Shield within 31 days of the birth so that your membership records can be adjusted.

Coverage for children will end on the last day of the period for which premium has been accepted.

Children who are under your legal guardianship or who are in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, will be covered. In addition, if you have children who are not living with you but for whom you are required by law to provide health care coverage, those children will be covered.

Any children who are incapable of self - sustaining employment and are dependent upon you or other care Providers for lifetime care and supervision because of a disabling condition occurring prior to reaching the limiting age will be covered regardless of age as long as they were covered prior to reaching the limiting age as shown on your Schedule Page of this Policy.

This coverage does not include benefits for grandchildren (unless such children have been legally adopted or are under your legal guardianship).

### **Applying for Coverage**

You may apply for coverage in a Qualified Health Plan ("QHP") through the Exchange for yourself and/or your eligible family members (see below) by submitting the application(s) for individual medical insurance form along with any exhibits, appendices, addenda and/or other required information ("application(s)") to Blue Cross and Blue Shield and the Exchange, as appropriate. The application(s) for coverage may or may not be accepted. (Blue Cross and Blue Shield cannot use genetic information or require genetic testing in order to limit or deny coverage.)

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, Claim experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health status related factor. You will not be discriminated against for coverage under this Policy on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

You may enroll in or change QHPs for yourself and/or your eligible dependents during one of the following enrollment periods. Your and/or your eligible family member's effective date will be determined by Blue Cross and Blue Shield and the Exchange, as appropriate, depending upon the date your application is received, payment of the initial premiums no later than the day before the effective date of coverage (unless any Advanced Premium Tax Credit is greater than the initial premium), and other determining factors.

Blue Cross and Blue Shield and the Exchange, as appropriate, may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an eligible dependent under this Policy.

### **Annual Open Enrollment Period/Effective Date of Coverage**

You may apply for or change coverage in a QHP through the Exchange for yourself and/or your eligible dependents during the annual open enrollment period designated by the Exchange.

When you enroll during the annual open enrollment period, your and/or your eligible dependents effective date will be the following January 1, unless otherwise designated by the Exchange and Blue Cross and Blue Shield, as appropriate.

Coverage under this Policy is contingent upon timely receipt by Blue Cross and Blue Shield of necessary information and initial premium.

This provision "Annual Open Enrollment Period/Effective Date of Coverage" is subject to change by the Exchange, Blue Cross and Blue Shield, and/or applicable law, as appropriate.

### **Special Enrollment Periods/Effective Dates of Coverage**

Special enrollment periods have been designated during which you may apply for or change coverage in a QHP through the Exchange for yourself and/or your eligible dependents. You must apply for coverage within 60 days from the date of a special enrollment event, except as otherwise provided below in order to qualify for the changes described in this "Special Enrollment Periods/Effective Dates of Coverage" provision.

Unless otherwise designated by the Exchange, if your application is received on or before the day of the qualifying event, the effective date is the first day of the month following the qualifying life event. Unless otherwise designated by the Exchange, if the application is received after the qualifying event, the effective date is the first of the month following the date of receipt of the application.

You must provide acceptable proof of a qualifying event with your application. Special enrollment qualifying events are discussed in detail below. Blue Cross and Blue Shield will review this proof to verify your eligibility for a special enrollment. Failure to provide acceptable proof of a qualifying event with your application will delay or prevent the processing of your application and enrollment in coverage. Please call the customer service number on the back of your identification card or visit our website at [www.bcbsil.com](http://www.bcbsil.com) for examples of acceptable proof for the following qualifying events.

#### **Special Enrollment Events:**

You may reference an up to date listing of on-exchange special enrollment qualifying life events via <https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>.

**Coverage resulting from any of the special enrollment events is contingent upon timely completion of the application including proof of such event and remittance of the appropriate premiums in accordance with the guidelines as established by the Exchange and Blue Cross and Blue Shield, as appropriate.**

This provision "Special Enrollment Periods" is subject to change by the Exchange, Blue Cross and Blue Shield, and/or applicable law or regulatory guidance, as appropriate. Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application(s), including proof of such event and remittance of the appropriate premiums in accordance with the guidelines as established by the Exchange and Blue Cross and Blue Shield.

This provision "Special Enrollment Periods/Effective Date of Coverage" is subject to change by the Exchange, Blue Cross and Blue Shield, and/or applicable law, as appropriate.

### **PAYMENT OF PREMIUMS**

1. Premiums are due and payable on the due date.
2. The initial premium for Individual Coverage is based on your age at the time your coverage begins and the initial premium for Family Coverage is based on your age, your spouse's age or your party to a Civil Union or Domestic Partner's age and any eligible dependent children at the time coverage is applied for, as permitted by law.
3. Blue Cross and Blue Shield may establish a new premium for any of the benefits of this Policy on any of the following dates or occurrences:
  - a. Whenever the benefits of this Policy are increased, which may occur whenever required by applicable law or as directed by regulatory interpretation;

- b. Whenever the number of persons covered under this Policy is changed;
  - c. Whenever you move your residence from one geographical rating area to another; or
  - d. Whenever there is a change in your eligible dependent's tobacco use.
4. If the ages upon which the premium is based have been misstated, an amount which will provide Blue Cross and Blue Shield with the correct premium from your Coverage Date shall be due and payable upon billing or receipt from Blue Cross and Blue Shield.
5. In the event you are not receiving an Advanced Premium Tax Credit, a grace period of 31 days or such other grace period, if any, permitted by applicable law or regulatory guidance will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force, however, Claim Payments for Covered Services received during the grace period may be pended until full premium payment is made, and during the grace period your Providers and Pharmacies may require you to pay for your health care and prescription drug expenses in full. After the grace period, coverage under this Policy will automatically terminate on the last day of the coverage period for which premiums have been paid, unless coverage is extended as described below.
- If you pay your premium in full during the grace period, then you may submit a Claim to Blue Cross and Blue Shield for any expenses that you paid to your Providers and pharmacies during the grace period. See the *How to File A Claim* section for additional information.
- If you fail to pay premiums to Blue Cross and Blue Shield and/or Exchange within the grace period, this Policy will automatically terminate. During such grace period this Policy will continue in force, subject to the right of Blue Cross and Blue Shield to terminate this Policy in accordance with the "Termination of Coverage" provision of this Policy. If coverage is terminated for non-payment of premium, any Claims received and paid for during the grace period will be billed to you.
6. In the event you are receiving an Advanced Premium Tax Credit, you have a three - month grace period, or such other grace period, if any, permitted by applicable law or regulatory guidance for paying the full premiums falling due after the first premium. If full premium is not paid for you and your eligible dependents within one month of the premium due date, Claim Payments for Covered Services received during the second and third month's grace period under this Policy will be pended until full premium payment is made. If full payment of the premium is not made within the three - month grace period, then coverage under this Policy will automatically terminate on the last day of the first month of the three - month grace period. During the grace period, Blue Cross and Blue Shield will:
- a. Pay all appropriate Claims for services rendered during the first month of the grace period and may pend Claims for services rendered in the second and third months of the grace period, if any;
  - b. Notify the Department of Health and Human Services of such non - payment; and
  - c. Notify Providers of the possibility of denied Claims during the second and third months of your grace period, if any.

The grace periods and time periods during which your Claims will be pended are subject to change as permitted by applicable law, regulation or guidance.

The required premiums are determined and established by Blue Cross and Blue Shield based on your age, place of residence, tobacco use, and the number of dependents covered under this Policy according to the schedules filed with the Illinois Department of Insurance. Premiums will be calculated based on the age of each individual to be included under this Policy.

A Tobacco User may be subject to a premium increase of up to 1.5 times the rate applicable to those who are not Tobacco Users, to the extent permitted by applicable law or regulatory guidance, provided that Blue Cross and Blue Shield will

provide an opportunity to offset such premium variation through participation in a wellness program to prevent or reduce Tobacco Use, if required by applicable law.

Your premium will not be adjusted more often than annually except for:

1. Changes to or as otherwise expressly permitted by state or federal laws and regulations; or
2. Changes to coverage classification (for example, to a new age category or geographic location, or from a member coverage to a family member coverage type)

If premium is paid beyond the effective date of the premium change, Blue Cross and Blue Shield may require you to pay an additional premium or accept a refund (whichever is necessary). Premium payments should be sent to:

Blue Cross and Blue Shield of Illinois  
P. O. Box 3240  
Naperville, IL 60566-7240

Blue Cross and Blue Shield of Illinois does not accept payments of premium directly from third parties except for Permitted Premium Payments. Blue Cross and Blue Shield does not accept Prohibited Third Party Premium Payments.

#### **When Premiums Are Not Paid on Time**

The grace periods for this Policy are described above under Payment of Premiums. After the grace period, coverage under this Policy will automatically terminate on the last day of the coverage period for which premiums have been paid, unless coverage is extended as described in the next paragraph.

In the event you are receiving an Advanced Premium Tax Credit under the Affordable Care Act, you have a three - month grace period for paying the full premiums falling due after the first premium. If full premium is not paid within one month of the premium due date, Claim Payments for Covered Services received during the second and third calendar months of the grace period under this Policy will be pended until the full premium payment is made. If full payment of the premium is not made within the three - month grace period, then coverage under this Policy will automatically terminate on the last day of the first month of the three - month grace period. Blue Cross and Blue Shield will not process any Claims for services after the date of termination.

#### **REINSTATEMENT**

Any applicant whose previous Blue Cross and Blue Shield contract was terminated for good cause is eligible to re - enroll in this Policy, only during the open enrollment and special enrollment period as applicable, by submitting application(s) to the Exchange and Blue Cross and Blue Shield, as applicable.

#### **TERMINATION OF COVERAGE/WHEN COVERAGE ENDS**

If your coverage in a QHP is terminated for any reason, Blue Cross and Blue Shield will provide you with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage, or such other notice, if any, permitted by applicable law or regulatory guidance except as otherwise provided in this Policy.

Blue Cross and Blue Shield will also notify the Exchange of the termination effective date and the reason for termination.

You and your eligible dependents' coverage will be terminated due to the following events and will end on the dates specified below:

1. You terminate your coverage in a QHP, including as a result of your obtaining other minimum essential coverage, with reasonable, appropriate notice to the Exchange and Blue Cross and Blue Shield. For purposes of this provision, reasonable notice is defined as 14 days from the requested effective date of determination.

The last day of coverage will be:

- a. The termination date specified by you, if you provide reasonable notice;

- b. 14 days after the termination is requested by you, if you do not provide reasonable notice; or
  - c. On a date determined by Blue Cross and Blue Shield, if Blue Cross and Blue Shield is able to effectuate termination is fewer than 14 days and you request an earlier termination effective date.
2. When you are no longer eligible for QHP coverage through the Exchange. The last day of coverage is the last day of the month following the month in which the notice is sent by the Exchange, unless you request an earlier effective date.
  3. When Blue Cross and Blue Shield does not receive the premium payment on time or when there is a bank draft failure of premiums for your and/or your eligible dependents' coverage, and
    - a. In the event you are receiving an Advanced Premium Tax Credit, the grace period (described above) for individuals receiving an Advanced Premium Tax Credit (described above) has been exhausted. The last day of coverage will be the last day of the first month of the grace period. Blue Cross and Blue Shield will pay all appropriate Claims for services rendered to you and/or your eligible dependents during the first month of the grace period and may pend Claims for service rendered to you and your eligible dependents in the second and third months of the grace period; or
    - b. In the event you are not receiving an Advanced Premium Tax Credit, after the 31 - day grace period has been exhausted, the last day of coverage will be the last day of the coverage period for which premiums have been paid, unless coverage is extended as described below. Also, if coverage is terminated, any Claims received and paid for during the grace period will be billed to you. Blue Cross and Blue Shield applies its termination Policy for non - payment of premium uniformly to Enrollees in similar circumstances.
  4. Your coverage has been rescinded. See the definition of "Rescission" for additional information in the *Definitions Section* of this Policy.
  5. This QHP terminates or is decertified.
  6. You change from this QHP to another during an annual open enrollment period or special enrollment period. The last day of coverage in this QHP is the day before the effective date of coverage in your new QHP.

The above termination events, Claim pend dates and coverage termination dates are subject to change as permitted by applicable law, or regulatory guidance.

Cancellation of your coverage under this Policy terminates the coverage of all your dependents under this Policy.

Benefits will not be provided for any services or supplies received after the date coverage terminates under this Policy, unless specifically stated otherwise in this Policy or below under the heading "Extension of Benefits in Case of Discontinuance of Coverage". However, termination of your coverage will not affect your benefits for any services or supplies that you received prior to your termination date.

#### **Extension of Benefits in Case of Discontinuance of Coverage**

If you are Totally Disabled at the time this Policy terminates, benefits will be provided for (and limited to) the Covered Services described in this Policy which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's Policy due to the absence of coverage in this Policy. Benefits will be provided for a period of no more than 12 months from the date of termination. These benefits are subject to all of the terms and conditions of this Policy including, but not limited to, the requirements regarding Primary Care Provider referral. It is your responsibility to notify Blue Cross and Blue Shield, and to provide, when requested by Blue Cross and Blue Shield, written documentation of your disability. This extension of benefits does not apply to the Outpatient Prescription Drug Program Benefits section of this Policy.

## **CHILD - ONLY COVERAGE**

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

1. The parent or legal guardian is not covered and is not eligible for benefits under this Policy.
2. If a child covered under this Policy acquires a new eligible child of his/her own, the new eligible child may be enrolled in his/her own coverage if application for coverage is made within 60 days.
3. If a child is 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 Blue Cross and Blue Shield and the Exchange, as appropriate. For any child under 18 covered under this Policy, any obligations set forth in this Policy, 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 who 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 Policy must apply for their own individual Policy and must sign or authorize the application(s).

## **YOUR OVERALL PROGRAM DEDUCTIBLE**

The dollar amount each Member must pay for In-Network Covered Medical Expenses and Out-of-Network Covered Medical Expenses incurred during the Benefit Period before The Plan will make payment for any Covered Medical Expense to which the Deductible applies. The In-Network and Out-of-Network Deductibles are separate, and one does not accumulate to the other.

Only the Allowable Fee for Covered Medical Expenses and the insulin Copayment is applied to the Deductible. Thus, Copayment and/or Coinsurance, noncovered services, and amounts billed by nonparticipating providers do not apply to the Deductible and are the Member's responsibility.

If two or more Members covered under the same Family Membership satisfy the family Deductible as shown on the Schedule of Benefits in a single Benefit Period, the Deductible does not apply for the remainder of that Benefit Period for any Member of the Family Membership.

If a Member is in the Hospital on the last day of the Member's Benefit Period and continuously confined through the first day of the next Benefit Period, only one In-Network or Out-of-Network Deductible will be applied to that Hospital stay (facility charges only). If the Member satisfied the Member's Deductible prior to that Hospital stay, no Deductible will be applied to that stay.

## **YOUR PRIMARY CARE PROVIDER**

At the time of application, each person applying for Membership must select a Primary Care Provider from the MyBlue Plus POS Provider Network. Each Family Member must select a Primary Care Provider, although the Primary Care Provider may be different for each Family Member. If a Primary Care Provider is not selected, The Plan will assign a Primary Care Provider for each Family Member. Each Family Member must always have a Primary Care Provider.

Participating Primary Care Providers have contracted with the MyBlue Plus POS Provider Network and have agreed to accept Members for care and to adhere to the network's policies concerning waiting time for appointments, on-call coverage, preventive care, credentialing, and quality improvement. Primary Care Providers generally include general practitioners, family practitioners, internists, OB/GYNs, Woman's Principal Health Care Provider and pediatricians.

### **Services Performed by the Primary Care Provider**

The Member's Primary Care Provider is responsible for providing and arranging for the Member's health care except for Urgent Care or Emergency Services. Any follow-up care after Urgent Care or Emergency Services should be coordinated by the Member's Primary Care Provider or

If it is Medically Necessary in the Primary Care Provider's judgment, the Primary Care Provider will recommend a specialist who will provide services for the specific episode of care. The specialist and the Member's Primary Care Provider will coordinate the management of care.

### **Referrals**

Although referrals are not required for certain services, it is extremely important that care be coordinated by the Member's Primary Care Provider. All health care services should be provided by or arranged by the Member's Primary Care Provider. Any referrals, including standing referrals for specialty care, are coordinated by the Member's Primary Care Provider.

The Member may self-refer for services provided by an obstetrician or gynecologist. This self-referral is for any obstetrical (maternity) and gynecological examination or care, or services required as the result of any obstetrical or gynecological examination or condition. In order to receive the highest level of payment from The Plan, the Member must receive services from an In-Network provider who is an obstetrician or gynecologist.

### **Changing the Primary Care Provider Selection**

A Member may choose to select a different Primary Care Provider no more than once every Month. Any selection of a new Primary Care Provider must be communicated to and approved by The Plan and the change will be effective the first of the Month following the request.

As a participant in this benefit program, a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield website at [www.bcbsil.com](http://www.bcbsil.com) for a list of Participating Providers or you can request a copy of the Provider directory by contacting customer service.

### **Transition of Care Benefits**

If you are a new MyBlue Plus POS Enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy, and your Physician does not belong to Blue Cross and Blue Shield's network, but is within Blue Cross and Blue Shield's service area, you may request the option of transition of care benefits. You must submit a written request to Blue Cross and Blue Shield for transition of care benefits within 15 business days of your eligibility effective date. Blue Cross and Blue Shield may authorize transition of care benefits for a period of up to 90 days from the effective date of enrollment. Authorization of benefits is dependent on the Physician's agreement to contractual requirements and submission of a detailed treatment plan. A written notice of Blue Cross and Blue Shield's determination will be sent to you within 15 business days of receipt of your request.

If you are a current MyBlue Plus POS Enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy and your Primary Care Provider leaves the Blue Cross and Blue Shield network, you may request the option of continuity of care benefits as described in the

"Continuity of Care" provision in the *Other Things You Should Know* section. You must submit a written request to Blue Cross and Blue Shield for continuity of care benefits within 30 business days after receiving notification of your Primary Care Provider's termination.

Blue Cross and Blue Shield may authorize transition of care benefits for a period up to 90 days. Authorization of benefits is dependent on the Primary Care Provider's agreement to contractual requirements and submission of a detailed treatment plan.

A written notice of the determination will be sent to you within 15 business days of receipt of your request.

## **PYHICIAN BENEFITS**

This section lists the Covered Services under your Certificate.

**Please note that services must be determined to be Medically Necessary by the Plan in order to be covered under this Certificate.** Coverage of items and services provided to you is subject to Blue Cross and Blue Shield of Illinois policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, utilization management, and clinical payment and coding policies, which are updated throughout the plan year. These policies are resources utilized by Blue Cross and Blue Shield of Illinois when making coverage determinations and lay out the procedure and/or criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item. The clinical payment and coding policies are intended to ensure accurate documentation for services performed and require all providers to submit Claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Under the clinical payment and coding policies, Claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines. Coverage for Covered Services is subject to the code edit protocols for services/procedures billed and Claim submissions are subject to applicable Claim review which may include, but is not limited to, review of any terms of benefit coverage, provider contract language, medical and medical management policies, utilization or clinical review or utilization management policies, clinical payment and coding policies as well as coding software logic, including but not limited to lab management or other coding logic or edits.

Any line on the Claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included in the Covered Charge and will not be eligible for payment by the Plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the provider rendering the item or service or submitting the Claim is participating or non-participating. The most up-to-date medical policies and clinical procedure and coding policies are available at [www.bcbsil.com](http://www.bcbsil.com) or by contacting a Customer Service Representative at the number shown on your Identification Card.

Remember, whenever the term "you" or "your" is used, we also mean all Eligible Family Members who are covered under Family Coverage.

### **COVERED SERVICES**

#### **Surgery**

Benefits are available for Surgery performed by a Physician, Podiatrist, or Dentist and for any related Diagnostic Services received on the same day as the Surgery. However, for services performed by a Podiatrist or Dentist, benefits are limited to those surgical procedures which may be legally rendered by them, and which would be payable under this Policy had they been performed by a Physician.

Benefits provided for oral Surgery (performed by a Physician or Dentist) are limited to the following services:

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

The following services are also part of your surgical benefits:

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Reserve Company, an Independent Licensee of  
the Blue Cross and Blue Shield Association

1. **Sterilization Procedures** — (even if they are voluntary). Benefits for sterilization procedures and follow-up services will not be subject to any Deductible Coinsurance and/or Copayment when such services are received from a Participating Provider.
2. **Anesthesia**—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for Anesthesia Services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon's office, Hospital or Ambulatory Surgical Facility if you are under age 26 and have been diagnosed with an Autism Spectrum Disorder or a developmental disability.

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

**Autism Spectrum Disorders** - 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:

- a. 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;
  - b. It is manifested before the age of 22.
  - c. It is likely to continue indefinitely; and
  - d. 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.
3. **Assist at Surgery** – when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.

### A1C Testing

This plan provides benefits for A1C Testing for prediabetes, type I diabetes, and type II diabetes, in accordance with prediabetes and diabetes risk factors identified by the United States Centers for Disease Control and Prevention.

### Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge. Your calendar year Deductible will not apply to this benefit. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

## **Medical Care**

Benefits are available for Medical Care visits when:

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

## **Consultations**

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

## **Mammograms**

Benefits for mammograms will be provided at the benefit payment level described in this Policy.

## **Electroconvulsive Therapy Radiation Therapy Treatments**

## **Allergy Injections and Allergy Testing**

## **Routine Foot Care**

Benefits will be provided for Medically Necessary routine foot care, when obtained from a licensed Provider.

## **Chemotherapy**

Benefits will be provided for non-self-injected intravenous cancer medications that are used to kill or slow the growth of cancerous cells.

## **Massage Therapy**

## **Tobacco Use Screening and Smoking Cessation Counseling Services Tobacco Cessation Drugs**

## **Vitamin D Testing**

This plan provides benefits for Vitamin D Testing in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention.

## **Diabetes Self-Management Training and Education**

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy and education programs that allow you to maintain a hemoglobin A1C level within the range identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management, operating within the scope of his or her license or certification. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in *Other Covered Services* section of this Policy. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for telehealth/telemedicine regular foot care examinations by a Physician or Podiatrist, and for licensed dietitian nutritionists and certified diabetes educators to counsel diabetics in their home to remove the hurdle of transportation for diabetes patients to receive treatment.

## **Growth Hormone Therapy**

This plan provides benefits for Medically Necessary growth hormone therapy.

## **Hormone Therapy to Treat Menopause**

This plan provides benefits for Medically-Necessary hormone therapy to treat menopause that has been induced by a hysterectomy.

### **Immune Gamma Globulin Therapy (IGGT)**

Benefits will be provided for immune gamma globulin therapy for covered persons diagnosed with a primary immune deficiency when prescribed as Medically Necessary by a Physician. Nothing shall prevent Blue Cross and Blue Shield from applying appropriate utilization review standards to the ongoing coverage of IGGT for persons diagnosed with a primary immunodeficiency. Subject to such utilization review standards, an initial authorization shall be for no less than three months and reauthorization may occur every six months thereafter. For persons who have been in treatment for two years, reauthorization shall be no less than every 12 months, unless more frequently indicated by a Physician.

### **Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)/Pediatric Acute Onset Neuropsychiatric Syndrome (PANS) Treatment**

Benefits will be provided for all Medically Necessary treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including coverage for Medically Necessary intravenous immunoglobulin therapy. Immunoglobulin therapy is also known as immune gamma globulin therapy.

### **Pediatric Neuromuscular, Neurological, or Cognitive Impairment**

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

### **Fibrocystic Breast Condition**

### **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.

### **Breast Cancer Pain Medication and Therapy**

Benefits will be provided for all Medically Necessary pain medication and therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically based and includes reasonably defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Benefits will also be provided for all Medically Necessary pain medication related to the treatment of breast cancer under the *Outpatient Prescription Drug Program Benefit* section of this Policy.

### **Breast Implant Removal Cardiovascular Disease Management**

Breastfeeding comprehensive lactation support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Electric breast pumps are limited to one per calendar year.

### **Diagnostic Service**

for those services related to covered Surgery or Medical Care. Such tests include, but are not limited to, x-ray, pathology services, Clinical Laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

### **Colorectal Cancer Screening**

Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National

Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the provision entitled, "Preventive Care Services" section of this Policy.

### **Emergency Accident Care Emergency Medical Care**

#### **Blood Glucose Monitors for Treatment of Diabetes**

Benefits are available for Medically Necessary blood glucose monitors (including non-invasive monitors and monitors for the blind) for which a Health Care Practitioner has written an order.

#### **Prosthetic Appliances**

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

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

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

#### **Orthotic Devices**

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. Your benefits for foot orthotics will be limited to two-foot orthotic devices or one pair of foot orthotic devices per Benefit Period.

#### **Pancreatic Cancer Screening**

This plan provides benefits for Medically Necessary pancreatic cancer screenings.

#### **Port-Wine Stain Treatment**

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

#### **Biomarker Testing**

This plan provides benefits for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition, including Medically Necessary home saliva cancer screenings once every twenty-four (24) months, if you are at high risk or showing symptoms of the disease being tested for.

#### **Bone Mass Measurement and Osteoporosis**

Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

#### **Breast Reduction Surgery**

This plan provides benefits for Medically Necessary breast reduction surgery.

#### **Cleft Lip and Palate**

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This plan provides benefits for Medically Necessary treatment and care for cleft lip and palate for children under the age of 19.

### **Experimental/Investigational Treatment**

Benefits will be provided for routine patient care in conjunction with Experimental/Investigational Treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your Physician is considered a Life Threatening Disease or Condition, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this Policy if not provided in connection with an Approved Clinical Trial program. Approval by a federal agency will be taken into consideration by Blue Cross and Blue Shield in assessing Experimental/Investigational status but will not be determinative. You and your Physician are encouraged to call customer services at the toll-free number on your identification card in advance to obtain information about whether a particular clinical trial is qualified.

### **Comprehensive Cancer Testing**

This plan provides benefits for Medically Necessary Comprehensive Cancer Testing, including, but not limited to, whole-exome genome testing, whole-genome sequencing, RNA sequencing, tumor mutation burden, and targeted cancer gene panels. This plan also provides benefits for Medically Necessary testing of blood or constitutional tissue for cancer predisposition testing as determined by a licensed Physician.

### **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. Your benefits for chiropractic and osteopathic manipulation will be limited to the maximum stated in your Policy. Your benefits for chiropractic and osteopathic manipulation will be limited to 25 visits per Benefit Period.

### **Durable Medical Equipment**

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

### **Amino Acid-Based Elemental Formulas**

Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the benefit payment level for Other Covered Services described in the *Other Covered Services* section of this Policy.

### **Rehabilitative Services Occupational Therapy**

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

### **Physical Therapy**

Benefits will be provided for Physical Therapy when rendered by a Physician or Physical Therapist; provided however, when the therapy is beyond the scope of the Physical Therapist's license, the Physical Therapist must be under the supervision of a Physician, and therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount,

frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis.

### **Speech Therapy**

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

### **Clinical Breast Examinations**

Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician. Benefits for clinical breast examinations will be provided at the benefit payment level described in the "Preventive Care Services" provision section of this Policy.

### **Diagnostic Colonoscopies**

Benefits will be provided for diagnostic colonoscopies, when determined to be Medically Necessary by a Physician, Advanced Practice Nurse, or Physician Assistant, after an initial screening.

### **Human Papillomavirus Vaccine**

Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. Unless otherwise stated, benefits will be provided at the benefit payment level described in the provision entitled, "Preventive Care Services" section of this Policy.

If you obtain the vaccine at a Pharmacy, benefits will be provided at the benefit payment level described in the provision entitled, "Vaccinations obtained through Participating Pharmacies" in the *Outpatient Prescription Drug Program Benefit section* of this Policy.

### **Shingles Vaccine**

Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration.

### **Routine Liver Screening**

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

### **Outpatient Contraceptive Services**

Benefits will be provided for injections, implants and Outpatient contraceptive services. Outpatient contraceptive services include, but are not limited to, consultations, patient education, counseling on contraception, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. In addition, benefits will be provided for Medically Necessary contraceptive devices, injections and implants approved by the federal Food and Drug Administration, as prescribed by your Physician, follow-up services related to drugs, devices, products, procedures, including but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

Benefits are available for contraceptive drugs and products shown on the Contraceptive Coverage List and will not be subject to any Deductible, Coinsurance Amount and/or Copayment Amount when received from a Participating Pharmacy Provider.

### **Pap Smear Test**

Benefits will be provided for an annual routine cervical smear or pap smear test. Unless otherwise stated, benefits will be provided at the benefit payment level described in the provision entitled, "Preventive Care Services" section of this Policy.

### **Prostate Cancer Screening**

Benefits will be provided for an annual routine prostate cancer screening.

### **Ovarian Cancer Screening**

Benefits will be provided for annual ovarian cancer screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

### **Prostate Test and Digital Rectal Examination**

Benefits will be provided for an annual routine prostate routine prostate-specific antigen test and digital rectal examination for males.

### **Routine Pediatric Hearing Examination**

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

### **HIV Screening and Counseling**

Benefits will be provided for HIV Screening and Counseling and prenatal HIV testing ordered by a Physician, Physician Assistant or Advanced Practice Registered Nurse who has a written collaborative agreement with a collaborating physician that authorizes these services, including but not limited to orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

## **HUMAN BREAST MILK COVERAGE**

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

1. The milk is prescribed by a licensed medical practitioner.
2. The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
3. The infant's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
4. The milk has been determined to be Medically Necessary for the infant; and
5. One or more of the following applies:
  - a. The infant's birth weight is below 1,500 grams.
  - b. The infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
  - c. The infant has infant hypoglycemia.
  - d. The infant has congenital heart disease.
  - e. The infant has had or will have an organ transplant.
  - f. The infant has sepsis; or
  - g. The infant has any other serious congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the infant.

Benefits for pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed medical practitioner, will be provided for a covered child between 6-12 months of age, if the following conditions have been met:

1. The milk is prescribed by a licensed medical practitioner.
2. The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
3. The infant's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
4. The milk has been determined to be Medically Necessary for the infant; and
5. One or more of the following applies:
  - a. The child has spinal muscular atrophy.
  - b. The child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity.
  - c. The child has had or will have an organ transplant; or
  - d. The child has a congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the child.

For more information about this benefit, you may visit our website at [www.bcbsil.com](http://www.bcbsil.com) or call customer service at the number on the back of your identification card.

### **Prenatal Vitamins**

Benefits will be provided for prenatal vitamins, when prescribed by a Physician or Advanced Practice Nurse.

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

1. Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked;
2. Unhealthy alcohol use screening and counseling;
3. Aspirin use for men and women for prevention of cardiovascular disease for certain ages;
4. Blood pressure screening;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions;
7. Colorectal cancer screening for adults over age 45;
8. Depression screening;
9. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease;
10. HIV screening for all adults at higher risk;
11. HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition, including baseline and monitoring services;
12. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
  - a. Diphtheria, Tetanus, Pertussis;
  - b. Diphtheria, Tetanus & Acellular Pertussis;

- c. Haemophilus influenzae type b (Hib);
  - d. Hepatitis A;
  - e. Hepatitis B;
  - f. Herpes Zoster (Shingles);
  - g. Human papillomavirus;
  - h. Influenza (Flu shot or Flu mist);
  - i. Measles, Mumps, Rubella;
  - j. Meningococcal;
  - k. MPOX;
  - l. Pneumococcal;
  - m. RSV;
  - n. Varicella; and
  - o. COVID-19.
13. Unhealthy alcohol and drug use screening and counseling;
14. Obesity screening and counseling;
15. Sexually transmitted infections (STI) counseling for adults at increased risk;
16. Tobacco use screening and cessation interventions for Tobacco Users;
17. Syphilis screening for adults at higher risk;
18. Exercise interventions to prevent falls in adults age 65 years and older who are at increased risk for falls;
19. Hepatitis C virus (HCV) screening for infection in adults aged 18 to 79 years;
20. Hepatitis B virus screening for persons at high risk for infection;
21. Counseling children, adolescents, and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
22. Whole body skin examination for lesions suspicious for skin cancer.
23. Mental health prevention and wellness visit
24. Lung cancer screening in adults 50 and older who have a 20-pack year smoking history and currently smoke or have quit within the past 15 years;
25. Screening for high blood pressure in adults age 18 years or older;
26. Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese;
27. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with:
  - a) no history of CVD, b) one or more risk factors for CVD (including, but not limited to, dyslipidemia, diabetes hypertension or smoking) and c) a calculated 10-year CVD risk of 10% or greater; and
28. Tuberculin testing for adults 18 years or older who are at higher risk or tuberculosis.

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

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1. Bacteriuria urinary culture screening or other infection screening for pregnant women;
2. BRCA counseling about genetic testing for women at higher risk and if recommended by a Provider after counseling, genetic testing;
3. Breast cancer mammography screenings, including breast tomosynthesis and, if determined to be Medically Necessary, a screening MRI and comprehensive ultrasound;
4. Breast cancer chemoprevention counseling for women at higher risk;
5. Breastfeeding comprehensive lactation support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Electric breast pumps are limited to one per calendar year;
6. Cervical cancer screening;
7. Chlamydia infection screening for younger women and women at higher risk;
8. Contraception: Certain FDA - approved contraceptive methods, sterilization procedures, and patient education and counseling;
9. Domestic and interpersonal violence screening and counseling for all women;
10. Daily supplements of .4 to .8 mg of folic acid for women who may become pregnant;
11. Diabetes screening after pregnancy;
12. Gestational diabetes screening for women after 24 weeks pregnant and those at high risk of developing gestational diabetes;
13. Gonorrhea screening for all women;
14. Hepatitis B screening for pregnant women at their first prenatal visit;
15. HIV screening and counseling for women;
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. Perinatal depression screening and counseling;
18. Osteoporosis screening for women over age 65, and younger women with risk factors;
19. Rh incompatibility screening for all pregnant women and follow - up testing for women at higher risk;
20. Tobacco use screening and interventions for all women, and expanded counseling for pregnant Tobacco Users;
21. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened;
22. Sexually transmitted infections (STI) counseling for adults at increased risk;
23. Syphilis screening for all pregnant women or other women at increased risk;
24. Well - woman visits to obtain recommended preventive services;
25. Urinary incontinence screening;
26. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence and device removal;
27. Aspirin use for pregnant women to prevent preeclampsia; and
28. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy;

29. Behavioral counseling to promote healthy weight gain during pregnancy; and
30. Behavioral counseling to maintain weight or limit weight gain to prevent obesity for women who are aged 40 or older; and
31. Female and male condoms.

**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 females;
5. Congenital hypothyroidism screening for newborns;
6. Critical congenital heart defect screening for newborns;
7. Depression screening for adolescents;
8. Development screening for children under age 3, and surveillance throughout childhood;
9. Dyslipidemia screening for children ages 9-11 and 17-21;
10. Bilirubin screenings for newborns;
11. Fluoride chemoprevention supplements for children without fluoride in their water source and topical Fluoride applications;
12. Fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption;
13. Gonorrhea preventive medication for the eyes of all newborns;
14. Hearing screening for all newborns, children and adolescents;
15. Height, weight and body mass index measurements;
16. Hematocrit or hemoglobin screening;
17. Hemoglobinopathies or sickle cell screening for all newborns;
18. HIV screening for adolescents at higher risk;
19. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
  - a. Diphtheria, Tetanus, Pertussis;
  - b. Diphtheria, Tetanus & Acellular Pertussis;
  - c. Haemophilus influenzae type b (Hib);
  - d. Hepatitis A;
  - e. Hepatitis B;
  - f. Herpes Zoster (Shingles);
  - g. Human papillomavirus;
  - h. Influenza (Flu shot or Flu mist);
  - i. Measles, Mumps, Rubella;

- j. Meningococcal;
  - k. MPOX;
  - l. Pneumococcal;
  - m. RSV;
  - n. Varicella; and
  - o. COVID-19.
20. Lead screening for children at risk for exposure;
21. Autism screening for children at 18 and 24 months of age;
22. Medical history for all children throughout development;
23. Obesity screening and counseling;
24. Oral health risk assessment for younger children up to six years old;
25. Phenylketonuria (PKU) screening for newborns;
26. Sexually transmitted infections (STI) prevention and counseling for adolescents;
27. Tuberculin testing for children at higher risk of tuberculosis;
28. Vision screening for children and adolescents;
29. Tobacco use interventions, including education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents;
30. Whole body skin examination for lesions suspicious for skin cancer.
31. Newborn blood screening; and
32. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a non-Participating Pharmacy may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximum, if applicable.

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

The FDA - approved contraceptive drugs and devices currently covered under this benefit provision are listed on the Contraceptive Coverage List. This list is available on Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com) and by contacting customer service at the toll - free number on your identification card. Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the Contraceptive Coverage List. You may, however, have coverage under other sections of this Policy, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The Contraceptive Coverage List and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

Preventive care services received from a Non-Participating Provider, a Non-Participating Pharmacy, or other routine Covered Services not provided for under this provision, may be subject to the Deductible, Coinsurance, Copayments and/or benefit maximums.

Benefits for vaccinations that are considered preventive care services will not be subject to any Deductible, Coinsurance, Copayments and/or benefit maximum when such services are received from a Participating Provider or Participating Pharmacy.

Vaccinations that are received from a Non-Participating Provider, a Non-Plan Provider facility, or a Non-Participating Pharmacy, or other vaccinations that are not provided for under this provision, may be subject to the Deductible, Coinsurance, Copayments and/or benefit maximum.

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 described elsewhere in your Policy, if applicable.

### **Long-term Antibiotic Therapy**

Benefits will be provided for Long-term Antibiotic Therapy, including necessary office visits and ongoing testing, for a person with a Tick-Borne Disease when determined to be Medically Necessary and ordered by a Physician after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.

An experimental drug will be covered as a Long-term Antibiotic Therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a Tick-Borne Disease if the drug has been approved by the United States Food and Drug Administration.

### **Telehealth and Telemedicine Services**

Telehealth/Telemedicine Services are covered, as defined in the Schedule Page of this Policy.

### **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 when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit.

Benefits for such 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](http://www.bcbsil.com) or call customer service at the number on the back of your identification card.

## **BENEFIT PAYMENT FOR PHYSICIAN SERVICES**

The benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

After you have met your program calendar year Deductible, benefits will be provided as described below.

### **Participating Provider**

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at the Participating Provider payment level for Surgical/Medical Covered Services as specified in the Schedule Page of this Policy, after you have met your calendar year Deductible, unless otherwise specified in this Policy. Dentists are not Participating Providers but will be treated as such for purposes of benefit payment made under this Policy and may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

When you receive Covered Services (except for those services specified below) in a Participating Provider's office (other than a specialist's office), benefits for Covered Services, including all related Covered Services received on the same day will be provided at the Physician's office payment level specified on the Schedule Page of this Policy. Your calendar year Deductible will not apply.

When you receive Covered Services (except for those services specified below) in a Participating Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the same day, will be provided at the specialist's office payment level specified on the Schedule Page of this Policy.

When you receive Covered Services for Diagnostic Services or certain Diagnostic tests (CT scan, PET scan, or MRI) you may be responsible for a per procedure Copayment or Coinsurance amount in addition to your calendar year Deductible specified on the Schedule Page of this Policy.

Benefits for certain Diagnostic tests may require a Copayment or Coinsurance amount specified on the Schedule Page of this Policy.

This Copayment or Coinsurance amount is subject to change or increase as permitted by applicable law or regulatory guidance.

A specialist is a Provider who is not a:

1. Behavioral Health Practitioner.
2. Certified Nurse-Midwife.
3. Certified Nurse Practitioner.
4. Certified Clinical Nurse Specialist.
5. Clinical Professional Counselor.
6. Clinical Social Worker.
7. Clinical Laboratory.
8. Marriage and Family Therapist.
9. Mixed psychiatric group.
10. Mixed specialty group.
11. Neuro Psychologist.
12. Optician.
13. Optometrist; or
14. Retail Health.

Clinic or a Physician in:

1. Clinical psychology.
2. Family practice.
3. General practice.
4. Gynecology.
5. Internal medicine.
6. Obstetrics.
7. Obstetrics/gynecology.
8. Pediatrics; or
9. Psychiatry.

The following Covered Services are not subject to the office visit Copayment, and benefits will be provided at the general medical/surgical payment level, unless otherwise specified in this Policy:

1. Surgery.
2. Occupational Therapy.
3. Physical Therapy.
4. Speech Therapy.
5. Chiropractic and osteopathic manipulation.
6. Diagnostic Services.
7. CT scan, PET scan and MRI.

#### **Non-Participating Provider**

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at the Physician payment level for Non-Participating Providers as shown on the Schedule Page of this Policy, after you have met your calendar year Deductible.

When you receive Covered Services, in a Participating Hospital or in a Participating Ambulatory Surgical Facility and, due to any reason, Covered Services are provided by an anesthesiologist (including a Certified Registered Nurse Anesthetist), pathologist, radiologist, neonatologist, emergency room Physician, assistant surgeon (if the primary surgeon is a Participating Provider) or other Physician who is not a Participating Provider are unavailable from a Participating Provider and Covered Services are provided by a Non-Participating Provider, you will incur no greater Out-of-Pocket costs than you would have incurred if the Covered Services were provided by a Participating Provider. However, in the event that you willfully choose to receive Covered Services in a Participating Hospital or in a Participating Ambulatory Surgical Facility from a Non-Participating Provider who is an anesthesiologist (including a Certified Registered Nurse Anesthetist), pathologist, radiologist, neonatologist, emergency room Physician, assistant surgeon (if the primary surgeon is a Participating Provider) or other Physician, when a Participating Provider is available to provide the Covered Services, the preceding sentence will not apply to you and the Non-Participating Provider benefit level will apply.

#### **Participating and Non-Participating Provider Emergency Care**

Benefits for Emergency Accident Care and Emergency Medical Care will be provided at the Physician payment level for Participating Providers as shown on the Schedule Page of this when services, that meet the definition of Emergency Accident Care and Emergency Medical Care, are rendered by either a Participating Provider or a Non-Participating Provider in a Hospital emergency department. Your calendar year Deductible will apply. Non-emergency services provided in a Hospital emergency department for treatment of Mental Illness or Substance Use Disorder will be paid the same as Emergency Medical Care and Emergency Accident Care services.

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

**These Copayment amounts are subject to change or increase as permitted by applicable law or regulatory guidance.**

Participating Professional Providers are:

1. Acupuncturists.
2. Audiologists.
3. Physicians.

4. Podiatrists.
5. Psychologists.
6. Certified Clinical Nurse Specialists.
7. Certified Nurse-Midwives.
8. Certified Nurse Practitioner.
9. Certified Registered Nurse Anesthetists.
10. Durable Medical Equipment Providers.
11. Naprapaths.
12. Home Infusion Therapy Providers.
13. Chiropractors.
14. Clinical Social Workers.
15. Clinical Professional Counselors.
16. Clinical Laboratories.
17. Marriage and Family Therapists.
18. Physical Therapists.
19. Occupational Therapists.
20. Speech Therapists.
21. Optometrists.
22. Orthotic Providers.
23. Prosthetic Providers.
24. Registered Dieticians.
25. Registered Surgical Assistants; or
26. Retail Health Clinics

who have signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Professional Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service—that is, your calendar year Deductible, Copayment and Coinsurance amounts.

**Non-Participating Professional Providers are:**

1. Acupuncturists.
2. Audiologists.
3. Physicians.
4. Podiatrists;
5. Psychologists.
6. Dentists.

7. Certified Clinical Nurse Specialists.
8. Certified Nurse-Midwives.
9. Certified Nurse Practitioner.
10. Certified Registered Nurse Anesthetists.
11. Durable Medical Equipment Providers.
12. Naprapaths.
13. Home Infusion Therapy Providers.
14. Chiropractors.
15. Clinical Social Workers.
16. Clinical Professional Counselors.
17. Clinical Laboratories.
18. Marriage and Family Therapists.
19. Physical Therapists.
20. Occupational Therapists.
21. Speech Therapists.
22. Optometrists.
23. Orthotic Providers.
24. Prosthetic Providers.
25. Registered Dieticians.
26. Registered Surgical Assistants.
27. Retail Health Clinics; or
28. other Professional Providers

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

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Professional Provider, contact your Professional Provider or Blue Cross and Blue Shield.

Regarding the Schedule of Maximum Allowances, you should also understand the following:

1. If two or more surgical procedures are related or performed in the same operative area and are performed by the same or different Physician, Dentist or Podiatrist during the same operation, benefits will be provided only for the procedure which has the larger Maximum Allowance.
2. If two or more surgical procedures are related or are performed in the same operative area and are performed on different dates by the same or a different Physician, Dentist or Podiatrist, benefits will be based upon the procedure which has the largest Maximum Allowance and 50% of the Maximum Allowance for the procedure which has the next largest allowance.
3. Procedures performed for conditions resulting from the same accident or injury are considered related.

4. If a surgical procedure is repeated during an Inpatient stay, the benefit payment will be based upon 50% of the Maximum Allowance for such repeat procedure and only one such repeat will be considered a Covered Service.

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

## HOSPITAL BENEFITS

This section of your Policy explains what your benefits are when you receive care in a Hospital or other health care facility. Benefits are only available for services rendered by a Hospital unless another Provider is specifically mentioned in the description of the service.

Remember, to receive benefits for Covered Services, they must be ordered or approved by your Primary Care Provider.

Whenever we use "you" or "your" in describing your benefits, we mean all eligible family members who are covered under Family Coverage.

### COVERED SERVICES

#### Inpatient Benefits

You are entitled to benefits for the following services when you are an Inpatient in a Hospital or Skilled Nursing Facility:

1. **Bed, board and general nursing care when you are in:**
  - a. A semi - private room or a private room – must be authorized by your Primary Care Provider.
  - b. An intensive care unit.
2. **Ancillary services (such as operating rooms, drugs, surgical dressings and lab work).**
3. **Rehabilitative Therapy** (including, but not limited to Physical, Occupational and Speech Therapy).

#### Mental Illness and Substance Use Disorder Services

Benefits for all of the Covered Services described under this Certificate are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorders. Benefits for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder includes pregnancy and postpartum periods.

You are also entitled to Inpatient benefits for the diagnosis and/or treatment of Mental Illness when you are in a Residential Treatment Center.

No benefits will be provided for admissions to a Skilled Nursing Facility or a Residential Treatment Center which are for Custodial Care Services or because care in the home is not available or is unsuitable.

#### Number of Inpatient Days

There are no limits on the number of days available to you for Inpatient care in a Hospital or other eligible facility.

#### Outpatient Hospital Covered Services

The following are Covered Services when you receive them from a Hospital (or other specified Provider) as an Outpatient:

1. **Surgery** – when performed in a Hospital or Ambulatory Surgical Facility. Benefits for Surgery also include Surgery for morbid obesity (including, but not limited to bariatric Surgery).
2. **Diagnostic Services** – that is, tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury.
3. **Radiation Therapy** – that is, the use of ionizing radiation in the treatment of a medical illness or condition, including proton beam therapy.
4. **Reconstructive Services** –  
this plan provides benefits for Medically Necessary reconstructive services to restore physical appearance due to trauma.
5. **Chemotherapy** – that is, the treatment of malignancies with drugs.
6. **Electroconvulsive Therapy**

7. **Infusion Therapy**
8. **Renal Dialysis Treatments and Continuous Ambulatory Peritoneal Dialysis Treatment** – when received in a Hospital or a Dialysis Facility. Benefits for treatment in your home are available if you are homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and are rendered under the supervision of a Hospital or Dialysis Facility health care professional.

## **Special Programs**

You are entitled to benefits for the special programs listed below. The services covered under these programs are the same as those that are available when you are an Inpatient in a Hospital.

These programs are as follows:

1. **Coordinated Home Care Program**
2. **Pre-Admission Testing** – This is a program in which preoperative tests are given to you as an Outpatient in a Hospital to prepare you for Surgery that you are scheduled to have as an Inpatient.
3. **Partial Hospitalization Treatment Program** – This is a Hospital's planned therapeutic treatment program, which has been approved by your Participating IPA or Participating Medical Group or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment, in which patients spend days. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an Inpatient unit, i.e. medically supervised by a Physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Participants at this level of care do not require 24-hour supervision and are not considered a resident at the program. Requirements: Blue Cross and Blue Shield requires that any Mental Illness and/or Substance Use Disorder Partial Hospitalization Treatment Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by the plan as set forth in its current credentialing Policy, and otherwise meets all other credentialing requirements set forth in such Policy.
4. **Tobacco Use Cessation Program**
5. **Intensive Outpatient Treatment Program** – This is a Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder. Requirements Blue Cross and Blue Shield requires that any Mental Illness and/or Substance Use Disorder Intensive Outpatient Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by the plan as set forth in its current credentialing Policy, and otherwise meets all other credentialing requirements set forth in such Policy.
6. **Approved Clinical Trials** – Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life - Threatening Disease or Condition and is recognized under state and/or federal law.
7. **Autism Spectrum Disorder(s)** – Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) your Primary Care Provider who has determined that such care is Medically Necessary, or (b) a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder(s) and when the care is determined to be Medically Necessary and ordered by your Primary Care Provider:
  - a. Psychiatric care, including Diagnostic Services;

- b. Psychological assessment and treatment;
  - c. Habilitative or rehabilitative treatment;
  - d. Therapeutic care, including behavioral Occupational Therapy, Physical Therapy and Speech Therapy 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.
8. **Habilitative Services** – Your benefits for Habilitative Services are the same as your benefits for any other condition if all of the following conditions are met:
- a. A Physician has diagnosed the Congenital, Genetic or Early Acquired Disorder; and
  - b. 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 your Primary Care Provider; and
  - c. Treatment must be Medically Necessary and therapeutic and not Experimental/Investigational.

### **Surgical Implants**

Your coverage includes benefits for surgically implanted internal and permanent devices. Examples of these devices are internal cardiac valves, internal pacemakers, mandibular reconstruction devices, bone screws and vitallium heads for joint reconstruction.

### **Mastectomy Related Services**

Benefits will be provided for Covered Services related to mastectomies, including, but 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) post mastectomy care for Inpatient treatment for a length of time determined by the 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.

### **Maternity Services**

Your benefits for services rendered in connection with pregnancy are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. In addition to all of the previously described Covered Services, routine Inpatient nursery charges for the newborn child are covered, even under Individual Coverage. (For Family Coverage, if the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, that care will be covered from the moment of birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage. Premiums will be adjusted accordingly. For Individual Coverage benefits will not be provided for any treatment of an illness or injury to a newborn child unless you have Family Coverage. (Remember, you must add the newborn child within 31 days of the date of birth.)

### **Coverage will be provided for the mother and the newborn (if the newborn is added to the Family Policy) for a minimum of:**

1. 48 hours of Inpatient care following a vaginal delivery; or
2. 96 hours of Inpatient care following a delivery by caesarean section.

except as may be indicated by the following: A shorter length of Hospital Inpatient stay related to maternity and newborn care may be provided if the attending Physician determines, in accordance with the protocols and guidelines developed by

the American College of Obstetrics and Gynecologists or by the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother and newborn. Such an earlier discharge may only be required if there is coverage and availability of a post - discharge Physician office visit or an in - home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, Blue Cross and Blue Shield will not provide benefits for such care.

### **Other Reproductive Health Services**

Your coverage includes benefits for abortion care. Benefits for abortion care are the same as your benefits for any other condition, under this *Hospital Benefits* Section.

### **URGENT CARE**

This benefit provides Medically Necessary Outpatient care if you are outside the Blue Cross and Blue Shield's service area and experience an unexpected illness or injury that would not be considered an Emergency Condition, but which should be treated before returning home. Services usually are provided at a Physician's office. If you require such urgent care, you should contact 1 - 800 - 810 - BLUE. You will be given the names and addresses of nearby participating Physicians and Hospitals that you can contact to arrange an appointment for urgent care.

#### **Your Cost for Urgent Care Treatment**

100% of the Provider's Charge will be paid for urgent care received outside of the Blue Cross and Blue Shield's service area. You will be responsible for any Copayment(s) or Coinsurance, if applicable.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the *Hospital Benefits* and *Physician Benefits* sections of this Policy. Your Primary Care Provider is responsible for coordinating all of your health care needs. Therefore, it is especially important for you or your family to contact your Primary Care Provider as soon as possible if Inpatient Hospital care is required.

### **FOLLOW-UP CARE**

If you will be traveling and know that you will require follow - up care for an existing condition, contact 1 - 800 - 810 - BLUE. You will be given the names and addresses of nearby participating Physicians that you can contact to arrange the necessary follow - up care. (Examples of follow - up care include removal of stitches, removal of a cast, Physical Therapy, monitoring blood tests, and kidney dialysis).

#### **Your Cost for Follow-Up Care Treatment**

100% of the Provider's Charge will be paid for follow - up care received outside of the Blue Cross and Blue Shield's service area. You will be responsible for any Copayment(s) or Coinsurance, if applicable.

### **Benefits for Covered Services Received in Hospital and Freestanding Facility**

Benefits for Outpatient Surgery, Certain Diagnostic Tests, Diagnostic X-ray Services and Outpatient Laboratory Services will be at the benefit level set forth in the Schedule Page.

### **YOUR COST FOR PHYSICIAN SERVICES**

Benefits for all Outpatient office visits, including all related Covered Services received on the same day (except for Outpatient CT scans, PET scans, MRIs and Outpatient Diagnostic Services) are subject to the office visit Copayment amount shown on your Schedule Page per visit and then will be paid in full at no cost to you.

However, the following Covered Services of this benefit section are not subject to the office visit Copayment shown on your Schedule Page and benefits will be paid in full at no cost to you:

1. Outpatient periodic health examinations;
2. Preventive care services;
3. Routine pediatric care;
4. Routine vision examinations;
5. Chiropractic and osteopathic manipulation; and
6. Maternity services after the first pre-natal visit.
7. Whole body skin examination for lesions suspicious for skin cancer.
8. Mental health prevention and wellness visit

Benefits for Outpatient office visits to a Specialist Physician's office are subject to a separate Copayment amount shown on your Schedule Page and then will be paid in full at no cost to you.

Benefits for Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy are subject to the Copayment amount shown on your Schedule Page per treatment, unless otherwise specified in this Policy, and then will be paid in full at no cost to you.

Benefits for all Outpatient Diagnostic Services are subject to the Copayment amount shown on your Schedule Page per procedure, unless otherwise specified in this Policy, and then will be paid in full at no cost to you.

Benefits for all Outpatient CT scans, MRIs, and PET scans are subject to the Copayment amount shown on your Schedule Page per procedure, unless otherwise specified in this Policy, and then will be paid in full at no cost to you.

When you receive Covered Services for Outpatient Surgery, you are responsible for paying the Copayment amount as shown on your Schedule Page per visit, if applicable, then benefits will be paid in full at no cost to you.

The Covered Services of this benefit section will be paid as described above when such services are received from a:

1. Physician;
2. Physician Assistant;
3. Certified Nurse Midwife;
4. Certified Nurse Practitioner;
5. Certified Registered Nurse Anesthetist;
6. Certified Clinical Nurse Specialist; or
7. Marriage and Family Therapist.

#### **YOUR COST FOR INPATIENT HOSPITAL SERVICES**

Covered Services for Inpatient Hospital Services will be paid in full, with no cost to you, except as shown on your Schedule Page, after you have met the program deductible.

Each time you are admitted as an Inpatient to a Hospital, Skilled Nursing Facility or Residential Treatment Center, you must satisfy the Inpatient Copayment amount as shown on the Schedule Page, if applicable. The Inpatient Copayment is a separate Copayment from the program deductible. However, if your admission to a Skilled Nursing Facility or Residential Treatment Center immediately follows an Inpatient Hospital stay, then the Inpatient Copayment will not apply to such admission. After you have satisfied the program deductible and the Inpatient Copayment, benefits for Covered Services will be paid at the Coinsurance amount shown on your Schedule Page, if applicable.

Benefits for Covered Services you receive during a Virtual Visit will be provided at the payment level shown on the Schedule 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.

## **YOUR COST FOR OUTPATIENT HOSPITAL SERVICES**

Covered Services for Outpatient Hospital Services are covered in full, with no cost to you, except as specifically mentioned below.

Benefits for Outpatient Surgery are subject to the Copayment amount shown on your Schedule Page per visit and then you will be responsible for the Coinsurance amount shown on your Schedule Page, after you have met your program deductible shown on your Schedule Page.

## **UTILIZATION MANAGEMENT AND REVIEW**

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

Refer to the definition of Medically Necessary under the *Definitions* section of this Certificate for additional information regarding any limitations pertaining to your benefits.

### **PRIOR AUTHORIZATION**

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

**If Prior Authorization is required, the review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions of this Certificate. Blue Cross and Blue Shield recommends you confirm with your Provider if Prior Authorization has been obtained.**

### **PRIOR AUTHORIZATION RESPONSIBILITY**

#### **Participating Provider Prior Authorization**

Your Participating Provider is responsible for obtaining Prior Authorization, in those circumstances where authorization may be required. If Prior Authorization is not obtained and the services are denied as not Medically Necessary, the Participating Provider will be held responsible and will not be able to bill the Member for the services. For additional information about Prior Authorization for services outside of our services area, refer to the Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements Notice in the **NOTICES** section of this Certificate.

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

**Note:** Providers that contract with other Blue Cross and Blue Shield Plans may not be familiar with the Prior Authorization requirements of BCBSIL. Unless a Provider contracts directly with BCBSIL as a Participating Provider, the Provider is not responsible for being aware of this Plan's Prior Authorization requirements, except as described in the section "The

BlueCard Program® in the General Provisions".

### **Non-Participating Provider Prior Authorization**

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

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

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

## SUPPLEMENTAL BENEFITS

When you are being treated for an illness or injury, your treatment may require the use of certain special services or supplies in addition to those provided in the other benefit sections of this Policy. Your coverage includes benefits for certain supplemental services and supplies and this section of your Policy explains what those benefits are.

Remember, these services and supplies must be provided or ordered by your Primary Care Provider.

### COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

1. **Blood and Blood Components**
2. **Outpatient Private Duty Nursing Service** – Benefits for Outpatient Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care Provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Outpatient 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 Outpatient Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
3. **Medical and Surgical Dressings, Supplies, Casts and Splints**
4. **Oxygen and its administration**
5. **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 calendar year.
6. **Prosthetic Devices** – Benefits will be provided for prosthetic devices, including those determined by your Provider to be most appropriate for physical activities, such as running, biking, swimming and lifting, special appliances and surgical implants required for an illness or injury when:
  - a. They are required to replace all or part of an organ or tissue of the human body; or
  - b. They are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.Adjustments, repairs and replacements of these devices, appliances and implants are also covered when required because of wear or a change in your condition. Benefits will not be provided for dental appliances or as otherwise provided for in the *Physician Benefits* section of this Policy, or for replacement of cataract lenses unless a prescription change is required.
7. **Hearing Implants**—Benefits will be provided for bone anchored Hearing Aids and cochlear implants.
8. **Orthotic Devices** – that is, a supportive device for the body or a part of the body, head, neck or extremities including, but not limited to leg, back, arm and neck braces, and those determined by your Provider to be most appropriate for physical activities, such as running, biking, swimming and lifting. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition as determined by your Primary Care Provider. Benefits for foot orthotics will be limited to a maximum of two devices or one pair of devices per calendar year.
9. **Durable Medical Equipment** – that is, durable equipment which primarily serves a medical purpose, is appropriate for home use and generally is not useful in the absence of injury or disease. Benefits will be provided for the rental of a piece of equipment (not to exceed the total cost of equipment) or purchase of cardiopulmonary monitors. Durable medical equipment must be rented or purchased from a plan contracting durable medical equipment Provider. Examples of durable medical equipment are wheelchairs, Hospital beds, glucose monitors, lancet and lancing devices and ventilators. Compression sleeves to prevent or mitigate lymphedema. Benefits will not be

provided for strollers, electric scooters, back-up or duplicate equipment, ramps or other environmental devices, or clothing or special shoes.

#### **YOUR COST FOR COVERED SERVICES**

You are responsible for the Coinsurance amount shown on your Schedule Page for the Covered Services specified above after you have met your program deductible, if any.

## **EMERGENCY CARE BENEFITS**

This section of your Policy explains your emergency care benefits.

### **Emergency Room Care**

1. Emergency room care for an accidental Injury.
2. Emergency room care for Emergency Services.
3. Emergency room care for the treatment of Mental Illness and/or Substance Use Disorder.

If the Member disagrees with The Plan's determination in processing Benefits as nonemergency services instead of Emergency Services, the Member may call The Plan at the number on the back of the Member's identification card. Please see the section entitled How to File an Internal Appeal of an Adverse Benefit Determination in this document for specific information on the Member's right to seek and obtain a full and fair review of the claim.

### **IN - AREA TREATMENT OF AN EMERGENCY**

The Plan will pay for Emergency Services when provided by an emergency room, subject to the applicable Deductibles, Copayments and/or Coinsurance. If the Member is admitted to the Hospital from the emergency room as a result of the condition requiring Emergency Services, any applicable emergency room Copayment or per occurrence Deductible will be waived. Plan payment and Member responsibility will be determined according to the Hospital Services Inpatient Care Services section.

To facilitate the coordination of follow-up care, the Member should notify their Primary Care Provider and The Plan of the Emergency Services within 24 hours or on the first working day after the day the services were provided.

### **OUT-OF-AREA TREATMENT OF AN EMERGENCY**

If you are more than 30 miles away from your Participating IPA/Participating Medical Group and need to obtain treatment for an Emergency Condition, benefits will be provided for the Hospital and Physician services that you receive. Benefits are available for the initial treatment of the emergency and for related follow - up care but only if it is not reasonable for you to obtain the follow - up care from your Primary Care Physician or Woman's Principal Health Care Provider. If you are unsure whether or not you are in your Participating Individual Practice Association's/Participating Medical Group's treatment area, you can call customer service at the toll-free telephone number on the back of your Blue Cross and Blue Shield Identification Card or they will be identified in the HMO Provider Directory.

### **EMERGENCY AMBULANCE BENEFITS**

Benefits for emergency ambulance transportation are available when:

1. Such transportation is ordered by your Primary Care Provider; or
2. The need for such transportation has been reasonably determined by a Physician, public safety official or other emergency medical personnel rendered in connection with an Emergency Condition.

Benefits are available for transportation between your home or the scene of an accident or medical emergency and a Hospital or Skilled Nursing Facility. If there are no facilities in the local area equipped to provide the care needed, benefits will be provided for transportation to the closest facility that can provide the necessary services. Benefits will not be provided for long distance trips or for the use of an ambulance because it is more convenient than other transportation.

You will be responsible for the Coinsurance amount shown on your Schedule Page after you have met your program deductible for emergency ambulance transportation.

Licensed ground and air ambulance transport required for a Medically Necessary condition to the nearest appropriate site.

## **SUBSTANCE USE DISORDER TREATMENT BENEFITS**

Your coverage includes benefits for the treatment of Substance Use Disorder.

Covered Services are the same as those provided for any other condition, as specified in the other benefit sections of this Policy. In addition, benefits are available for Covered Services provided by a Substance Use Disorder Treatment Facility or a Residential Treatment Center in the MyBlue POS network, when ordered by your PCP or WPHCP.

### **INPATIENT BENEFITS**

There are no limits on the number of days available to you for care in a Hospital or other eligible facility.

### **BENEFIT PAYMENT FOR INPATIENT BENEFITS**

Each time you are admitted as an Inpatient to a Hospital, Substance Use Disorder Treatment Facility or Residential Treatment Center, you are responsible for paying the Copayment amount shown on your Schedule Page, after you have met your program deductible, if applicable. After the Copayment, you will be responsible for the Coinsurance amount as shown on your Schedule Page, if applicable.

### **COST TO YOU FOR OUTPATIENT BENEFITS**

Benefits for Outpatient office visits for Substance Use Disorder Treatment are subject to the Copayment amount shown on your Schedule Page per visit and then will be paid at 100% of the Provider's Charge.

However, benefits for Outpatient Substance Use Disorder Treatment visits to a Specialist Physician's office are subject to the Copayment amount shown on your Schedule Page per visit and then benefits for Covered Services will be paid at 100% of the Provider's Charge.

### **Detoxification**

Covered Services received for detoxification are not subject to the Substance Use Disorder Treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the *Hospital Benefits* and *Physician Benefits* sections of this Policy, as for any other condition.

## **HUMAN ORGAN TRANSPLANT BENEFITS**

Your coverage includes benefits for human organ and tissue transplants when ordered by your Primary Care Provider and when performed at a Blue Cross and Blue Shield approved center for human organ transplants. To be eligible for benefits, your Primary Care Provider must contact the office of the Blue Cross and Blue Shield of Illinois' Medical Director prior to scheduling the transplant Surgery.

All of the benefits specified in the other benefit sections of this Policy are available for Surgery performed to transplant an organ or tissue. In addition, benefits will be provided for transportation of the donor organ to the location of the transplant Surgery, limited to transportation in the United States or Canada. Benefits will also be available for immunosuppressive drugs, donor screening and identification costs, under approved matched unrelated donor programs and immunosuppressive drugs. Payment for Covered Services received will be the same as that specified in those benefit sections. If there is a change that alters the terms of coverage for prescribed immunosuppressive drugs, Blue Cross and Blue Shield shall notify you or your authorized representative along with your prescribing Physician at least 60 days prior to making such change. The notice shall describe the change and include information your prescribing Physician's right to appeal such change.

Benefits will be provided for both the recipient of the organ or tissue and the donor subject to the following rules:

1. If both the donor and recipient have coverage with Blue Cross and Blue Shield, each will have his/her benefits paid by his/her own program.
2. If you are the recipient and your donor does not have coverage from any other source, the benefits of this Policy will be provided for both you and your donor. The benefits provided for your donor will be charged against your coverage under this Policy.
3. If you are the donor and coverage is not available to you from any other source, the benefits of this Policy will be provided for you. However, benefits will not be provided for the recipient.

Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Primary Care Provider, and you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and one or two companion(s). For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

1. Benefits for transportation and lodging are limited to a combined maximum of \$10,000 per transplant. The maximum amount that will be provided for lodging is \$50 per person per day.
2. Benefits for lodging will be provided at 100% of the Transplant Lodging Eligible Expense.

In addition to the other exclusions of this Policy, benefits will not be provided for the following:

1. Organ transplants, and/or services or supplies rendered in connection with an organ transplant, which are Experimental/Investigational as determined by the appropriate technological body;
2. Drugs which are Experimental/Investigational;
3. Storage fees;
4. Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision;
5. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery;
6. Travel time or related expenses incurred by a Provider;
7. Meals.

## HOSPICE CARE BENEFITS

Your coverage includes benefits for services received in a Hospice Care Program. For benefits to be available for these services, they must have been ordered by your Primary Care Provider.

In addition, they must be rendered by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less as certified by your Primary Care Provider; and you will no longer benefit from standard Medical Care, or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care Program;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services - Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Services.

The following services are not covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

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

Benefits are subject to the same payment provisions and day limitations specified in the *Hospital Benefits* and *Physician Benefits* sections of this Policy, depending upon the particular Provider involved (Hospital, Skilled Nursing Facility, Coordinated Home Care Program or Physician).

## OUTPATIENT PRESCRIPTION DRUG PROGRAM

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. Benefits will not be provided for any self-administered drugs dispensed by a Physician. This section of your Policy explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

Although you can go to the Pharmacy of your choice, benefits will only be provided for drugs and supplies when purchased through a Participating Pharmacy. However, benefits for drugs and supplies when purchased outside of a Participating Pharmacy network will only be provided in the case of an emergency condition. You can visit Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com) for a list of Participating Pharmacies or Specialty Pharmacies or call the customer service toll-free number on your identification card. The Pharmacies that are Preferred Participating Pharmacies, Participating Pharmacies and Preferred Specialty Pharmacy Provider may change. You should check with your Pharmacy before obtaining drugs or supplies to make certain of its participation status.

The benefits of this section are subject to all of the terms and conditions of this Policy. Please refer to the *Definitions, Eligibility, and Exclusions – What Is Not Covered* sections of this Policy for additional information regarding any limitations pertaining to your benefits.

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

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

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

**COINSURANCE AMOUNT** – means a Copayment that is a percentage amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

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

**COPAYMENT AMOUNT** – means the dollar amount or Coinsurance Amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

**COVERED DRUGS** – means any Legend Drug (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self-administration):

1. Which is Medically Necessary and is ordered by a Health Care Practitioner naming you as the recipient;
2. For which a written or verbal Prescription Order is provided by a Health Care Practitioner;
3. For which a separate charge is customarily made;
4. Which is not consumed or administered at the time and place that the Prescription Order is written;

5. For which the FDA has given approval for at least one indication; and
6. Which is dispensed by a Pharmacy and is received by you while covered under this benefit section, except when received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the "Exclusions" provision later in this benefit section).

**DRUG LIST** – means a list of all drugs that may be covered under the Outpatient Prescription Drug Program Benefit section of this Policy. A current list is available on our website at <https://www.bcbsil.com/rx-drugs/drug-lists/drug-lists>. You may also contact a customer service representative at the telephone number shown on the back of your identification card for more information.

**ELIGIBLE CHARGE** – means (a) in the case of a Provider which has a written agreement with Blue Cross and Blue Shield or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with Blue Cross and Blue Shield or the entity chosen by Blue Cross and Blue Shield to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

1. The charge which the particular Pharmacy usually charges for Covered Services; or
2. The agreed upon cost between Participating Pharmacy and Blue Cross and Blue Shield or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, whichever is lower.

**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 Covered Drugs Blue Cross and Blue Shield utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information. Generic Drugs are listed on the *Drug List* which is available on Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com) You may also contact customer service at the toll-free number indicated on the back of your identification card.

**HEALTH CARE PRACTITIONER** – means an Advanced Practice Nurse, doctor of medicine, doctor of dentistry, Physician Assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

**LEGEND DRUGS** – means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

**MAINTENANCE DRUGS** – means drugs prescribed for chronic conditions and are taken on a regular basis to treat conditions such as high cholesterol, high blood pressure, or asthma.

**NON-PARTICIPATING PHARMACY OR NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER** – has the meaning set forth in the *Definitions Section* of this Policy.

**NON-PREFERRED BRAND NAME DRUG** – means a Brand Name Drug that is identified on the *Drug List* as a Non-Preferred Brand Name Drug. The "*Drug List*" is available by accessing the Blue Cross and Blue Shield website at [www.bcbsil.com](http://www.bcbsil.com).

**NON-PREFERRED GENERIC DRUG** – means a Generic Drug that is identified on the *Drug List* as a Non-Preferred Generic Drug. The "*Drug List*" is available by accessing the Blue Cross and Blue Shield website at [www.bcbsil.com](http://www.bcbsil.com).

**NON-PREFERRED SPECIALTY DRUG** – means a Specialty Drug, which may be a Generic or Brand Name Drug, that is identified on the "*Drug List*" as a Non-Preferred Specialty Drug. The *Drug List* is available by accessing the Blue Cross and Blue Shield website at [www.bcbsil.com](http://www.bcbsil.com).

**PARTICIPATING PHARMACY OR PARTICIPATING PRESCRIPTION DRUG PROVIDER** – has the meaning set forth in the *Definitions Section* of this Policy.

**PHARMACY** – has the meaning set forth in the *Definitions Section* of this Policy.

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**PREFERRED BRAND NAME DRUG** – means a Brand Name Drug that is identified on the *Drug List* as a Preferred Brand Name Drug. The “*Drug List*” is available by accessing the Blue Cross and Blue Shield website at [www.bcbsil.com](http://www.bcbsil.com).

**PREFERRED GENERIC DRUG** – means a Generic Drug that is identified on the *Drug List* as a Preferred Generic Drug. The *Drug List* is available by accessing the Blue Cross and Blue Shield website at [www.bcbsil.com](http://www.bcbsil.com).

**PREFERRED PARTICIPATING PHARMACY** – means a Participating Pharmacy which has a written agreement with the Plan or has a written agreement with an entity chosen by the Plan to administer its prescription drug program, to provide Covered Drugs to you at the time services are rendered, that has been designated as a Preferred Participating Pharmacy.

**PREFERRED SPECIALTY DRUG** – means a Specialty Drug, which may be a Generic or Brand Name Drug, that is identified on the “*Drug List*” as a Preferred Specialty Drug. The *Drug List* is available by accessing the Blue Cross and Blue Shield website at [www.bcbsil.com](http://www.bcbsil.com).

**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 benefit section.

**SPECIALTY DRUGS** – means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include high cost oral medications. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, you should refer to the “*Drug List*” by accessing Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com) or call the customer service toll-free number on your identification card.

**SPECIALTY PHARMACY PROVIDER** – means a Participating Prescription Drug Provider that has a written agreement with the plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide Specialty Drugs to you.

## ABOUT YOUR BENEFITS

### Drug List

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 existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the *Drug List*. Entire drug classes are also regularly reviewed. 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*.

Positive changes (e.g., adding drugs to the *Drug List*, drugs moving to a lower payment tier) occur quarterly after review by the committee. Changes to the *Drug List* that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or prior authorization) occur only annually. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the *Drug List* may occur more frequently.

The *Drug List* and any modifications will be made available to you. By accessing Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com) or calling the customer service toll-free number on your identification card, you will be able to determine the *Drug List* that applies to you and whether a particular drug is on the *Drug List*.

To the extent required by law, and subject to change as described above, all Covered Drugs indicated for the treatment of Substance Use Disorders are subject to the lowest Coinsurance Amount/Copayment Amount for a Generic Drug, Brand Name Drugs or Specialty Drugs, as applicable.

Your prescribing health care Provider, or your authorized representative, can ask for a *Drug List* exception if your drug is not on (or is being removed from) the *Drug List* or the drug required as part of step therapy or dispensing limits has been found to be (or likely to be) not right for you or does not work as well in treating your condition. To request this exception,

you, your prescribing Provider or your authorized representative, can call the number on the back of your identification card to ask for a review. Blue Cross and Blue Shield will let you, your prescribing Provider or authorized representative know the coverage decision within 72 hours after they receive your request. If the coverage request is denied, Blue Cross and Blue Shield will let you and your prescribing Provider (or authorized representative) know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals and external exception review process you will receive with the denial determination.

If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug, your prescriber may be able to ask for an expedited review process by marking the review as an urgent request. Blue Cross and Blue Shield will let you, your prescribing Provider or authorized representative know the coverage decision within 24 hours after they receive your request for an expedited review. If the coverage request is denied, Blue Cross and Blue Shield will let you and your prescribing Provider (or authorized representative) know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Call the number on the back of your identification card if you have any questions.

### **PRIOR AUTHORIZATION/STEP THERAPY REQUIREMENT**

Your Participating Provider is responsible for obtaining Prior Authorization, in those circumstances where authorization may be required. If Prior Authorization is not obtained and the services are denied as not Medically Necessary, the Participating Provider will be held responsible and will not be able to bill the Member for the services. For additional information about Prior Authorization for services outside of our services area, refer to the Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements Notice in the NOTICES section of this Certificate.

When certain medications and drug classes, such as medications used to treat rheumatoid arthritis, growth hormone deficiency and hepatitis C are prescribed, you will be required to obtain authorization from Blue Cross and Blue Shield in order to receive benefits. Medications included in this program are subject to change and other medications for other conditions may be added to the program. Although you may currently be on therapy, your Claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the brand name medication.

Blue Cross and Blue Shield's prescription drug administrator will send a questionnaire to your Physician upon your or your Pharmacy's request. The questionnaire must be returned to the prescription drug administrator who will review the questionnaire and determine whether the reason for the prescription meets the criteria for Medically Necessary care. You and your Physician will be notified of the prescription drug administrator's determination. Although you are not required to obtain authorization prior to purchasing the medication, you are strongly encouraged to do so, to help you and your doctor factor your cost into your treatment decision. If criteria for medical necessity is not met, coverage will be denied and you will be responsible for the full charge incurred.

To find out more about prior authorization/step therapy requirements or to determine which drugs or drug classes require prior authorization or step therapy, you should refer to the *Drug List* by accessing Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com) or call the customer service toll-free number on your identification card. Please see the "*Drug List*" provision for more information about changes to the programs.

### **Controlled Substances Limitation**

If it is determined that you may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary, appropriateness and coverage restrictions, which may include but not limited to limiting coverage to services provided by a certain Provider and/or Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. For the purpose of this provision, controlled substance medications are medications classified or restricted by state or federal laws. Additional Coinsurance Amount and/or Copayment Amount and any deductible may apply.

## **Day Supply**

In order to be eligible for coverage under this Policy, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation described in this Benefit section. Benefits under this benefit section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply, if allowed by your plan benefits. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed. For information on these drugs, call the customer service toll-free number located on your identification card. However, 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. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained. However, you may receive coverage for up to a 12-month supply for dispensed contraceptive drugs and products that are covered under this benefit section. For additional information about early refills, please see the "*Prescription Refills*" provision below.

## **Multi-Category Split Fill Program**

If this is your first time using select medications in certain drug classes (e.g., medications for cancer multiple sclerosis, lung disorders etc.) or if you have not filled one of these medications within 120 days, you may only be able to receive a partial fill (14–15-day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. If you receive a partial fill, your Copayments and/or Coinsurance after your deductible will be adjusted to align with the quantity of medication dispensed. If the medication is working for you and your Physician wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit the <https://www.bcbsil.com/rx-drugs/pharmacy/programs-hmo-members> website.

## **Dispensing Limits**

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by your Physician, Dentist, Optometrist or Podiatrist, 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.

The maximum quantity of a given prescription drug means the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by your Physician, Dentist, Optometrist or Podiatrist. To determine if a specific drug is subject to this limitation, you can refer to the *Drug List* by accessing Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com) or call the customer service toll-free number on your identification card.

If you require a Prescription Order in excess of the dispensing limit established by Blue Cross and Blue Shield, ask your Physician, Dentist, Optometrist or Podiatrist to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. Blue Cross and Blue Shield has the right to determine dispensing limits and they may change from time to time. Payment for benefits covered under this benefit section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

## **Prescription Refills**

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

1. The prescription drugs are covered under this Policy or have received an exception approval as described under the "*Drug List*" provision above;

2. The prescription drugs are maintenance medications and have refill quantities available to be refilled at the time of synchronization;
3. The medications are not Schedule II, III, or IV controlled substances as defined in the Illinois Controlled Substances Act;
4. All utilization management criteria (as described under the "Prior Authorization/Step Therapy Requirement" Provision above) for prescription drugs have been met;
5. The prescription drugs can be safely split into short-fill periods to achieve synchronization; and
6. The prescription drugs do not have special handling or sourcing needs that require a single, designated Pharmacy to fill or refill the Prescription Order.

When necessary to permit synchronization, Blue Cross and Blue Shield will prorate the Copayment Amount or Coinsurance Amount, on a daily basis, due for Covered Drugs based on the proportion of days the reduced Prescription Order covers to the regular day supply as shown on the Schedule Page of this Policy.

### **COVERED SERVICES**

Benefits for Medically Necessary Covered Drugs are available if the drug:

1. Has been approved by the FDA for the diagnosis and condition for which it was prescribed or
2. Has been approved by the FDA for at least one indication and is recognized by substantially accepted peer-reviewed medical literature for treatment of the indication for which the drug is prescribed to treat you for a chronic, disabling or life-threatening illness.

The Coinsurance Amount or Copayment Amount shown on your Schedule Page will apply to each fill of a medication having a unique strength, dosage, or dosage form.

### **Cancer Medications**

Benefits will be provided for orally administered cancer medications, or self-injected cancer medications that are used to treat cancer when a particular legend drug has been shown effective for the treatment of that specific type of cancer and if proper documentation is provided, even though that legend drug may not have FDA-approval for that type of cancer. The drug must have been shown to be effective for the treatment of that particular cancer according to the American Hospital Formulary Service Drug Information; National Comprehensive Cancer Network's Drugs & Biologics Compendium; Thomson Micromedex's Drug Dex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services. Your Deductible, Copayment Amount, or Coinsurance Amount will not apply to orally administered cancer medications when received from a Participating Pharmacy.

### **Specialty Drugs**

Benefits are available for Specialty Drugs as described under Specialty Pharmacy Program.

### **Immunosuppressant Drugs**

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

### **Self-Administered Cancer Medications**

Benefits will be provided for self-administered cancer medications, including pain medication.

### **Injectable Drugs**

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

## **Fertility Drugs**

Benefits are available for fertility drugs which are self-administered that require a written prescription by federal law.

## **Contraceptive Drugs**

Benefits are available under this benefit section for contraceptive drugs and products shown on the Contraceptive Coverage List. You may access the Blue Cross and Blue Shield website at [www.bcbsil.com](http://www.bcbsil.com) for more information.

Benefits for contraceptive drugs covered under this benefit section will not be subject to any deductible, Coinsurance Amount and/or Copayment Amount when such services are received from a Preferred Participating Pharmacy Provider.

## **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.

## **Opioid Medically Assisted Treatment**

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

## **Intranasal Opioid Reversal Agent**

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

**Note:** Benefits for naloxone hydrochloride, will be provided at no charge, when obtained from a Participating Pharmacy, after your program Deductible has been met.

## **Topical Anti-Inflammatory Acute and Chronic Pain Medication**

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

## **Long-term Antibiotic Therapy**

Benefits will be provided for Long-term Antibiotic Therapy, for a person with a Tick-Borne Disease, when determined to be Medically Necessary and ordered by your Primary Care Physician or Woman's Principal Health Care Provider after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.

Oral antibiotics will be covered under the Outpatient Prescription Drug Program. The member payment is indicated under the "Benefit Payment for Prescription Drugs" provision of this Policy.

An Experimental drug will be covered as a Long-term Antibiotic Therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an Experimental drug, shall be covered for an off-label use in the treatment of a Tick-Borne Disease if the drug has been approved by the United States Food and Drug Administration.

## **Diabetic Supplies for Treatment of Diabetes**

Benefits are available for Medically Necessary items of diabetic supplies and blood glucose monitors (including non-invasive monitors and monitors for the blind) for which a Health Care Practitioner has written an order. Such diabetes supplies shall include, but are not limited to, the following:

1. Test strips specified for use with a corresponding blood glucose monitor;
2. Lancets and lancet devices;
3. Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein;

4. Insulin and insulin analog preparations;
5. Injection aids, including devices used to assist with insulin injection and needleless systems;
6. Insulin syringes;
7. Biohazard disposable containers;
8. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels;
9. Glucagon emergency kits.

#### **Abortifacients**

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

#### **Hormonal Therapy for Gender Dysphoria**

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

#### **Vaginal Estrogen**

This plan provides benefits for Covered vaginal estrogen products or FDA-Approved therapeutic equivalents when determined to be Medically-Necessary.

#### **HIV Post-Exposure Prophylaxis**

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

#### **90-Day Supply Prescription Drug Program**

The 90-Day Supply Prescription Drug Program provides delivery of Covered Drugs directly to your home address. In addition to the benefits described in this benefit section, your coverage includes benefits for Maintenance Drugs and diabetic supplies obtained through the 90-Day Supply Prescription Drug Program. For information about this program, contact Blue Cross and Blue Shield or visit Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com).

Some drugs may not be available through the 90-Day Supply Prescription Drug Program. If you have any questions about the 90-Day Supply Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the mail order form, you may access Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com) or call the customer service toll-free number on your identification card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

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

#### **Specialty Pharmacy Program**

This program provides delivery of medications directly to your Health Care Practitioner, administration location or to your home if you are undergoing treatment for a complex medical condition. Due to special storage requirements and high cost, Specialty Drugs are not covered unless obtained through the Specialty Pharmacy Program. To determine which drugs are Specialty Drugs, you should refer to the *Drug List* by accessing Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com) or call the customer service toll-free number on your identification card.

The Specialty Pharmacy Program delivery service offers:

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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

1. Coordination of coverage between you, your Health Care Practitioner and Blue Cross and Blue Shield;
2. Educational materials about the patient's particular condition and information about managing potential medication side effects;
3. Syringes, sharp containers, alcohol swabs and other supplies with every shipment of FDA approved self- injectable medications; and
4. Access to a pharmacist 24 hours a day, 7 days a week, 365 days each year.

### **MedsYourWay™**

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

The amount you pay for your Prescription will be applied, if applicable, to your Deductible and out-of-pocket maximum. Available select Covered Drugs and drug discount card pricing through MedsYourWay may change occasionally but your cost with available select drugs through MedsYourWay will never be higher than the listed cost share on the schedule for the specific tier the drug is listed under. Certain restrictions may apply and certain Covered Drugs or drug discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount for select Covered Drugs depending upon which retail pharmacy is utilized. For additional information regarding MedsYourWay, please contact a Customer Service Representative at the toll-free telephone number on the back of your Identification Card. Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting your Customer Service Representative at the toll-free telephone number on the back of your Identification Card.

## **YOUR COST FOR PRESCRIPTION DRUGS**

### **How Member Cost is Determined**

The amount that you are responsible for is based upon the drug tiers as described below and shown on the Schedule Page of this Policy.

- Tier 1 – includes mostly Generic Drugs and may contain some Brand Name Drugs.
- Tier 2 – includes mostly Non-Preferred Generic Drugs and may contain some Brand Name Drugs.
- Tier 3 – includes mostly Preferred Brand Name Drugs and may contain some Generic Drugs.
- Tier 4 – includes mostly Non-Preferred Brand Name Drugs and may contain some Generic Drugs.
- Tier 5 – includes mostly Specialty Drugs and may contain some Generic Drugs.
- Tier 6 – includes mostly Non-Preferred Specialty Drugs and may contain some Generic Drugs.

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

If you or your Provider request a brand name drug when a generic drug is available, you will pay the applicable Copayment Amount and/or Coinsurance based on current tier of brand name drug plus the difference between the allowable amount of the brand name drug and the allowable amount of the generic drug, except as otherwise provided in the Policy. Any "differences" between the cost of the Generic Drug and the cost of the Brand Name Drug will apply to the deductible or out-of-pocket maximum. The applicable cost-sharing (by tier) and the cost difference between the generic and brand will never exceed the overall actual price of the drug.

To verify your payment amount for a drug, visit the Blue Cross and Blue Shield website at [www.bcbsil.com](http://www.bcbsil.com) and log in to Blue Access for Members<sup>SM</sup> or call the number on the back of your identification card. Benefits will be provided as shown on the Schedule Page of this Policy.

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

### **30-Day Supply Prescription Drug Program**

Benefit payment for the 30-day supply prescription drug program.

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

When you purchase drugs or diabetic supplies from a Participating Prescription Drug Provider, you will not be charged any amount other than the specified amounts shown on your Schedule Page. You will be charged the appropriate amount for each prescription.

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

One prescription means up to a 30 consecutive day supply for most medications. Certain drugs may be limited to less than a 30 consecutive day supply. In addition, you may receive coverage for up to a 12-month supply for dispensed contraceptives. However, for certain maintenance type drugs, larger quantities may be obtained through the 90-day supply prescription drug program. For additional information on these drugs, contact the customer service toll-free number on your identification card.

No benefits will be provided when you purchase drugs or diabetic supplies from a Non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider) in Illinois. However, if the Non-Participating Prescription Drug Provider is located outside of Illinois, then benefits for drugs or diabetic supplies purchased for emergency conditions will be provided and you will be responsible for the specified Coinsurance Amount or Copayment Amount shown on your Schedule Page. You will be charged the appropriate Coinsurance Amount or Copayment Amount for each prescription.

### **90-Day Supply Prescription Drug Program**

Benefit payment for the 90-day supply prescription drug program.

In addition to the benefits described in this benefit section, your coverage includes benefits for maintenance type drugs and diabetic supplies which may be purchased through a retail or mail order Pharmacy participating in the 90-day supply prescription drug program. You will not be charged any amount other than the appropriate Coinsurance Amount or Copayment Amount, specified on your Schedule Page.

You may also receive coverage for up to a 12-month supply for dispensed contraceptive.

Benefits will not be provided for 90-day supply drugs or diabetic supplies purchased from a Prescription Drug Provider not participating in the 90-day supply program.

Should you choose to obtain a 90-day supply Prescription Order from a mail order Pharmacy, contact Blue Cross and Blue Shield referencing the number on the back of your card or visit Blue Cross and Blue Shield's website at [www.bcbsil.com](http://www.bcbsil.com).

### **EXCLUSIONS**

For purposes of this benefit section only, the following exclusions shall apply:

1. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your benefit, the drug purchased will not be covered under any Benefit level;
2. Drugs determined to have inferior efficacy or significant safety issues;

3. Drugs/Products which are not included on the “*Drug List*”, unless specifically covered elsewhere in this Policy and/or such coverage is required in accordance with applicable law or regulatory guidelines;
  4. Non-FDA approved Drugs, which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug;
  5. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels and vaccinations administered through certain Participating Pharmacies); and drugs or covered devices for which no valid Prescription Order is obtained;
  6. Devices, Technologies, and/or Durable Medical Equipment of any type (even though such devices may require a Prescription Order) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies);
  7. Pharmaceutical aids, such as, excipients found in the USP-NF (United States Pharmacopeia-National Formulary) including but not limited to preservative, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents;
  8. Administration or injection of any drugs;
  9. Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative);
  10. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility;
  11. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper Claim be, provided under the Workers' Compensation law;
  12. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Vaccinations administered through certain Participating Pharmacies are an exception to this exclusion;
  13. Drugs which are repackaged by a company other than the original manufacturer;
  14. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this benefit section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed in excess of the amount of beyond the time period allowed by law;
  15. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Policy.
- NOTE:** This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases;
16. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control;
  17. Drugs, that the use or intended use of which would be illegal, abusive, not Medically Necessary, or otherwise improper;
  18. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card;

19. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction, which is not covered under this Policy, or for which benefits have been exhausted;
20. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise;
21. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging;
22. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined;
23. Athletic performance enhancement drugs;
24. Drugs to treat sexual dysfunction;
25. Allergy serum and allergy testing materials;
26. Some therapeutic equivalent drugs are manufactured under multiple names. In some cases, Blue Cross and Blue Shield may limit benefits to only one of the therapeutic equivalents available as specified on the *Drug List*. If you do not choose the therapeutic equivalents that are covered under the Outpatient Prescription Drug Program Benefit section, the drug purchased will not be covered under any benefit level;
27. Compound drugs;
28. Drugs determined to have inferior efficacy or significant safety issues;
29. Medications in depot or long-acting formulations that are intended for use longer than the covered days supply amount;
30. Benefits will not be provided for any self-administered drugs under this benefit section dispensed by a Physician;
31. Any portion of Covered Services or Covered Drugs paid for through Prohibited Third Party Cost Sharing Payments;
32. Institutional packs and drugs which are repackaged by anyone other than the original manufacturer;
33. Bulk Powders;
34. Diagnostic agents (except for diabetic testing supplies or test strips);
35. Certain drug classes where there are over-the-counter alternatives available; and
36. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
37. New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutics (P&T) Committee prior to coverage of the drug.

## PEDIATRIC VISION CARE BENEFITS

Your coverage includes benefits for pediatric vision care. This section of your Policy explains what those benefits are.

### DEFINITIONS

In addition to the definitions found in the *Definitions Section* of this Policy, the following definitions are applicable to your vision care benefits:

**Benefit Period** – For purposes of this *Pediatric Vision Care Benefits* section, a period of time that begins on the later of: 1) the member's effective date of coverage under this Policy, or 2) the last date a vision examination was performed on the member or that Vision Materials were provided to the member, whichever is applicable and continues for the next 12 months. Later Benefit Periods will begin on the first day that you receive a Covered Service after expiration of your prior Benefit Period. (A Benefit Period does not coincide with a calendar year and may differ for each covered member of a family).

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

**Low Vision** – means a significant loss of vision but not total blindness.

**Ophthalmologist** – means a duly licensed ophthalmologist.

**Optician** – means a duly licensed optician.

**Optometrist** – means a duly licensed optometrist.

**Vision Care Provider** – means any individual, partnership, proprietorship or organization lawfully and regularly engaged in the business of prescribing and/or dispensing corrective lenses prescribed by a Physician, a licensed Ophthalmologist or Optometrist operating within the scope of his/her license, or a dispensing Optician operating within the scope of his or her license.

**Participating Vision Care Provider** – is a Vision Care Provider which has a written agreement with Blue Cross and Blue Shield.

**Non-Participating Vision Care Provider** – is a Vision Care Provider which does not have a written agreement with Blue Cross and Blue Shield.

**Vision Materials** – Corrective Lenses and/or Frames.

### ELIGIBILITY

Children who are covered under this Policy, up to age 19, are eligible for coverage under this benefit section. NOTE: Once coverage is lost under this Policy, all benefits cease under this benefit section. Extension of benefits due to disability, state or federal continuation coverage option privileges are not available under this benefit section.

### COVERED SERVICES

Your vision care coverage provides benefits for:

1. **Lenses**
2. **Frames**
3. **Contact Lenses**
4. **Low Vision devices**
5. **Laser Vision Correction Surgery (Lasik)** – You are entitled to receive a discount for traditional and custom Lasik from participating Physicians and affiliated laser centers. You may call the customer service number on the back of your identification card for information on participating Physicians and affiliated laser centers.

You are entitled to receive one of the Covered Services above each Benefit Period. In addition, benefits will be provided for one vision examination each Benefit Period. However, additional benefits will be provided within the Benefit Period if a prescription change is required from previous Lenses covered under this benefit section. No additional benefits will be provided for tinted, photo-sensitive or anti-reflective Lenses above the benefit allowance for regular Lenses.

Benefits will be provided for one pair of Lenses and a Frame and/or one pair of Contact Lenses each Benefit Period.

Benefits will be provided for additional Lenses during a Benefit Period (but still subject to one total Benefit Period payment maximum) if required because the prescription for the Lenses has changed.

Benefits will also be provided for one comprehensive Low Vision evaluation every 5 years. Your benefits for Low Vision also include devices as high-powered spectacles, magnifiers and telescopes and for follow-up care. Follow-up care is limited to four visits every 5 years.

To be eligible for benefits, Lenses, Frames and Contact Lenses must be provided by a Participating Vision Care Provider. Benefits are not available for Lenses, Frames or Contact Lenses received from a Non-Participating Vision Care Provider.

Benefits are available for Covered Services rendered by a Physician, Optometrist or Optician.

If your coverage under this Policy should terminate, benefits will be provided for Lenses, Frames or Contact Lenses that were ordered prior to your termination date if you receive them within 30 days of your termination date.

## **HOW THIS VISION CARE PLAN WORKS**

Under the vision care plan, you may visit any Provider and receive benefits for a covered vision services and materials. In order to maximize benefits for most covered Vision Materials, however, you must purchase them from a Participating Vision Care Provider.

Before you go to a Participating Vision Care Provider for an eye examination, eyeglasses or Contact Lenses, please call ahead for an appointment. When you arrive, show the receptionist your identification card. If you forget to take your identification card, be sure to say that you are a member of the Blue Cross and Blue Shield vision care plan so that your eligibility can be verified.

To locate a Participating Vision Provider, visit the EyeMed Vision Care, LLC (EyeMed) website at [www.eyemed.com](http://www.eyemed.com) and use the Find a Provider link (choose the Select network for your search), or call 1-844-684-2254. If you obtain eyeglasses or Contact Lenses from a Non-Participating Vision Care Provider, you must pay the Provider in full and submit a Claim for reimbursement (see *How To File A Claim* section for more information).

Questions about services covered under the vision care plan, Participating Vision Care Providers or about benefits provided or denied under the plan can be directed to EyeMed seven days a week, Monday through Saturday, 6:30 A.M. to 10:00 P.M., and Sunday 10:00 A.M. to 7:00 P.M. (Central Time) at 1-844-684-2254. An Interactive Voice Response Unit is also available outside normal business operating hours. (Please direct member enrollment, termination and other subscriber or dependent eligibility questions to Blue Cross and Blue Shield of Illinois, not to EyeMed) Members using a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services through calling or using a TTY machine to engage an operator at 711 and asking the operator to call EyeMed at 1-844-230-6498. Customer service hours and operations are subject to change without notice.

You may receive your eye examination and eyeglasses/Contact Lenses 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 Provider and there may be additional professional charges if you seek Contact Lenses from a Provider other than one who performed your 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 benefit section, must be paid in full by you to the Provider, whether or not the Provider is a Participating Vision Care Provider. Benefits under this benefit section cannot be combined with any discount, promotional

offering, or other health benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

**Please see your Schedule Page for a complete schedule of pediatric vision care coverage.**

## **LIMITATIONS AND EXCLUSIONS**

In addition to the *Exclusions – What is Not Covered* section of this Policy, this benefit section does not cover services or supplies connected with or charges arising from:

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;
2. Aniseikonic spectacle lenses;
3. Medical and/or surgical treatment of the eye, eyes, or supporting structures;
4. Plano (nonprescription) lenses and/or Contact Lenses;
5. Nonprescription sunglasses (except for discount);
6. Services rendered after the date an insured person ceases to be covered under this Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order;
7. Services or materials provided by any other group benefit plan providing vision care;
8. Lost or broken lenses, frames, glasses or Contact Lenses will not be replaced except in the next benefit frequency when Vision Materials would next become available;
9. Any vision service, treatment or materials not specifically listed as a Vision Care Covered Service on your Schedule Page;
10. Services and materials that are Experimental/Investigational;
11. Services or materials which are prior to your effective date;
12. Services and materials incurred after the termination date of your coverage, unless otherwise indicated;
13. Services and materials not meeting accepted standards of optometric practice;
14. Services and materials resulting from your failure to comply with professionally prescribed treatment;
15. Telephone consultations;
16. Any charges for failure to keep a scheduled appointment;
17. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
18. Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in illegal occupation, or participating in a riot, rebellion or insurrection;
19. Office infection control charges;
20. Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
21. State or territorial taxes on vision services performed;
22. Medical treatment of eye disease or injury;
23. Visual therapy;
24. Special lens designs or coatings other than those described in this benefit section;

25. Replacement of lost or stolen eyewear;
26. Two pair of eyeglasses in lieu of bifocals;
27. Services not performed by licensed personnel;
28. Prosthetic devices and services;
29. Insurance of Contact Lenses; and
30. Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

## **PREADMISSION CERTIFICATION AND CONCURRENT REVIEW**

Preadmission Certification and Concurrent Review are two programs that have been established to ensure that you receive the most appropriate and cost-effective health care.

### **PREADMISSION CERTIFICATION**

Preadmission Certification applies when you need to be admitted to a Hospital as an Inpatient in other than an emergency situation. Prior to your admission, your Primary Care Provider must obtain approval of your admission.

### **CONCURRENT REVIEW**

Medical care rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or

Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Member's condition requires the skills of separate Physicians.

## **EXCLUSIONS — WHAT IS NOT COVERED**

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

1. Certain Services or supplies that require a referral or prior authorization by your Primary Care Provider except as explained in the *Emergency Care Benefits* section, *Hospital Benefits* section and for routine vision examinations, in the *Physician Benefits* section of this Policy;
2. Services or supplies provided outside of Illinois, with the following exceptions: (1) emergency or urgent care, (2) services or supplies received after the Member is granted an approved service area waiver, (3) Covered services or supplies received from Participating Providers in contiguous counties to Illinois. For more information about which counties are contiguous counties or to request a service area waiver for services or supplies provided outside of Illinois, contact Customer Service at the telephone number shown on your identification card.
3. Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated, unless otherwise stated in this Policy;
4. Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a Claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act;
5. Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received (except in the case of Medicare), except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 §1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law;
6. Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that Blue Cross and Blue Shield has provided benefits for the services or supplies rendered in connection with such injury;
7. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental/Investigational in nature, except as specifically provided for in this Policy for a) Routine Patient Costs associated with Experimental/Investigational treatment if you are a Qualified Individual participating in an Approved Clinical Trial, if those services or supplies would otherwise be covered under this Policy if not provided in connection with an Approved Clinical Trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s);
8. Custodial Care Service;
9. Long Term Care Services;
10. Respite Care Services, except as specifically mentioned under Hospice Care Benefits;
11. Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. However, this exclusion does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions);
12. Special education therapy such as music therapy or recreational therapy, except as specifically provided for in this Policy;

13. Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease;
14. Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group;
15. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage;
16. Charges for failure to keep a scheduled visit or charges for completion of a Claim form or charges for the transfer of medical records;
17. Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones;
18. Special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants, except as specifically stated in this Policy;
19. Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient or unrelated to the treatment of a disease or injury;
20. Services or supplies for:
  - intersegmental traction;
  - all types of home traction devices and equipment;
  - vertebral axial decompression sessions;
  - surface EMGs;
  - spinal manipulation under anesthesia;
  - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron; and
  - balance testing through computerized dynamic posturography sensory organization test.
21. Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements, except as stated in this Policy;
22. Blood derivatives which are not classified as drugs in the official formularies;
23. Hypnotism;
24. Inpatient Private Duty Nursing Service;
25. Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet-rich plasma;
26. Treatment of tissue damage or disease in any location with platelet-rich plasma;
27. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Policy;
28. Maintenance Care;
29. Self-management training, education and medical nutrition therapy, except as specifically stated in this Policy;
30. Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services;

31. Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth, except as specifically stated in this Policy;
32. Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging, or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation;
33. Testing of:
  - blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels;
  - urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover;
  - cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes); and
  - allergen specific IgG measurement.
  - Thyroid Disease Testing is not covered in the following situations:
    - Testing for thyrotropin-releasing hormone (TRH) or thyroxine-binding globulin (TBG) for the evaluation of the cause of hyperthyroidism or hypothyroidism is not covered.
    - Testing for thyroid dysfunction during a general exam without abnormal findings for asymptomatic nonpregnant individuals is not covered.
  - Onychomycosis Testing is not covered in the following situations:
    - Nucleic acid testing, attenuated total-reflectance fourier transform infrared (ATR-FTIR) spectroscopy and testing for the presence of fungal-derived sterols (e.g., ergosterol) to screen for, diagnose, or confirm onychomycosis is not covered.
34. Repair or replacement of appliances and/or devices due to misuse or loss, except as specifically mentioned in this Policy;
35. Services or supplies rendered for human organ or tissue transplants, except as specifically provided for in this Policy;
36. Wigs (also referred to as cranial prostheses), unless otherwise specified in this Policy;
37. Services or supplies rendered for Infertility treatment, except as specifically provided for in this Policy;
38. Eyeglasses, contact lenses, which are not Medically Necessary, or Hearing Aids, except as specifically provided for in this Policy;
39. Acupuncture, whether for medical or anesthesia purposes, dry needling, or trigger-point acupuncture;
40. Reversal of vasectomies;
41. Services and supplies rendered or provided outside of the United States, if the purpose of the travel to the location was for receiving medical services, supplies or drugs;
42. Any services and/or supplies provided to you outside the United States, unless they are received for an Emergency Condition, notwithstanding any provision in this Policy to the contrary;
43. Dental care, except as directly required for the treatment of a medical condition or as otherwise provided for in this Policy;
44. Benefits will not be provided for any self-administered drugs dispensed by a Physician;
45. Any related services to a non-covered service except for routine patient care for participants in an Approved Clinical Trial. Related services are:

- a. Services in preparation for the non-covered service;
  - b. Services in connection with providing the non-covered service;
  - c. Hospitalization required to perform the non-covered service; or
  - d. Services that are usually provided following the non-covered service, such as follow-up care, or therapy after Surgery.
46. Cannabis – This plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.

47. Fertility Preservation Services

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

In addition to the Definitions Section of this Policy, the following definitions are applicable to this provision:

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

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

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

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 Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

## **COORDINATION OF BENEFITS**

Coordination of Benefits (COB) applies to this Benefit Program when you or your covered dependent has health care coverage under more than one Benefit Program. COB does not apply to the Outpatient Prescription Drug Program Benefits.

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:

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but
2. 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 Service, when the Covered Service 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 your 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 or if it is the only room available.

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

**Benefit Program** – means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

1. Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan, or coverage required or provided 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 calendar year. However, it does not include any part of a year during which a person has no coverage under this Benefit Program, or any part of a year before the date this "COB" provision or a similar provision takes effect.

**Primary Program or Secondary Program** – means the order of payment responsibility as determined by the order of benefit determination rules.

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

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

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

### **ORDER OF BENEFIT DETERMINATION**

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

1. The other Benefit Program has rules coordinating its benefits with those of this Benefit Program; and

2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's benefits be determined before those of the other Benefit Program.

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

- a. Secondary to the Benefit Program covering the person as a dependent; and
- b. 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 or Divorced**

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

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

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

3. **Dependent Child if Parents Separated or Divorced**

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

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

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. The program of the other parent shall be the Secondary Program. This does not apply with respect to any Claim Determination Period or Benefit Program year during which any benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person Claiming benefits to notify the 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 Adults 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 neither a Benefit Program that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Benefit Program that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of benefits, this rule shall not apply.

## 7. Continuation Coverage

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

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

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

## 8. Length of Coverage

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

## WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

The benefits of this Benefit Program will be reduced when:

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

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

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

## RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. Blue Cross and Blue Shield has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield need not tell, or get the consent of, any person to do this. Each person Claiming benefits under this Benefit Program must give Blue Cross and Blue Shield any facts it needs to pay the Claim.

## FACILITY OF PAYMENT

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A payment made under another Benefit Program may include an amount that should have been paid under this Benefit Program. If it does, Blue Cross and Blue Shield 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. Blue Cross and Blue Shield 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 Blue Cross and Blue Shield is more than it should have paid under this "COB" provision, it may recover the excess from one or more of:

1. The persons it has paid;
2. Insurance companies; or
3. Other organizations.

The foregoing notwithstanding, you will only be responsible for any applicable Copayments, deductibles or Coinsurance as described in this Policy.

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

## **PLEASE NOTE, YOU MAY BE ENTITLED TO RECEIVE ADDITIONAL BENEFITS**

The amount by which your benefits under this Benefit Program have been reduced is called your "savings." Savings can be used to pay for services that are not covered under this Benefit Program provided that the services are covered under another Benefit Program and were not completely paid for under that Benefit Program. Savings can only be used to pay for services rendered in the same calendar year in which the Claim that earned the savings is actually processed.

Please notify Blue Cross and Blue Shield, by calling customer service, if there are expenses incurred during this calendar year which may entitle you to these additional benefits.

## **HOW TO FILE A CLAIM**

If a Member obtains Benefits from a Participating Provider, the Participating Provider will submit claims to The Plan for the Member. If a Member obtains Benefits from a nonparticipating provider, the Member may be required to submit all claims to The Plan. All claims for services must be submitted on or before December 31 of the calendar year following the year in which services were received. All claims must provide enough information about the services for The Plan to determine whether or not they are a Covered Medical Expense. Submission of such information is required before payment will be made. In certain instances, Blue Cross and Blue Shield of Illinois may require that additional documents or information including, but not limited to, Accident reports, medical records, and information about other insurance coverage, claims, payments and settlements, be submitted within the timeframe requested for the additional documentation before payment will be made.

There may be situations when you have to file a Claim yourself (for example, if a Provider will not file one for you). To do so, send the following to Blue Cross and Blue Shield:

1. An itemized bill from the Hospital, Physician or other Provider (including the Provider's name and address, the patient's name, the diagnosis (including appropriate codes), the date of service, a description of the service (including appropriate codes) and the Claim Charge);
2. The eligible person's name and Blue Cross and Blue Shield identification number;
3. The patient's name, age and sex; and
4. Any additional relevant information.

Mail all of that information to:

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

In any case, it is your responsibility to make sure that the necessary Claim information has been provided to Blue Cross and Blue Shield. Claims must be filed no later than December 31st of the calendar year following the year in which the Covered Service was rendered. For the purposes of this filing time limit, Covered Services rendered in December will be considered to have been rendered in the next calendar year.

If you have any questions about a Claim, call customer service at 1-800-892-2803.

## **FILING OUTPATIENT PRESCRIPTION DRUG PROGRAM CLAIMS**

In certain situations, you will have to file your own Claims in order to obtain benefits under the Outpatient Prescription Drug Program. This is primarily true when you did not receive an identification card, the Pharmacy was unable to transmit a Claim or you received benefits from a Non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete an Outpatient Prescription Drug Program Claim Form. These forms are available from Blue Cross and Blue Shield.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Prime Therapeutics  
P. O. Box 25136  
Lehigh Valley, PA 18002-5136

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received, will not be eligible for payment.

## **INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS INITIAL CLAIMS DETERMINATIONS**

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Blue Cross and Blue Shield will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is \$1.00 or less. Blue Cross and Blue Shield will usually notify you, your valid assignee, or your authorized representative when all information required to process a Claim in accordance with the terms of the benefit program within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provision in the *Other Things You Should Know* section of this Policy.)

#### If a Claim Is Denied or Not Paid in Full

If the Claim for benefit is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

1. The reasons for determination;
2. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;
3. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary;
4. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
5. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal. Specifically, this explanation will include:
  - a. An explanation that if your case qualified 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 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 d. below), and your Claim was denied for one of these reasons:
    - i. A decision about the medical need for or the Experimental status of a recommended treatment
    - ii. Your health care coverage was rescinded. For additional information, see the definition of Rescission in the *Definitions Section* of this Policy.

To ask for an external review, complete the Request for External Review form that will be provided to you and available at [insurance.illinois.gov/external-review](http://insurance.illinois.gov/external-review) and submit it to the Department of Insurance at the address shown below for external reviews;

- c. An explanation that you may ask for an expedited (urgent) external review if:
  - i. Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health or ability to regain maximum function;
  - ii. Blue Cross and Blue Shield failed to give you a decision within 48 hours of your request for an expedited appeal; or
  - iii. 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 Enrollee 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 with 48 hours of your request for an expedited appeal.
6. In certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
  7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield;
  8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits;
  9. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
  10. An explanation of the scientific or clinical judgment relied on in the determination as applied to Claimant's medical circumstances, if the denial was based on medical necessity, Experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
  11. In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such Claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the Claimant within three days of oral notification; and
  12. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:  
For complaints and general inquiries:

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

For external review requests:

Illinois Department of Insurance  
 Office of Consumer Health Insurance  
 External Review Unit  
 320 West Washington Street 4<sup>th</sup> Floor  
 Springfield, IL 62767  
 (877) 850-4740 Toll-free phone  
 (217) 557-8495 Fax number  
[DOI.externalreview@illinois.gov](mailto: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 you either orally or in writing.

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

1. Claims; and
2. Quality of care.

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

To pursue an Inquiry or a Complaint, you may contact customer service at the number on the back of your identification card, or you may write to:

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

When you contact customer service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by customer service. Sometimes the acknowledgement and the response will be combined. If Blue Cross and Blue Shield needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted. If an Inquiry or Complaint is not resolved to your satisfaction, you may appeal to Blue Cross and Blue Shield.

### Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

1. **Urgent Care Clinical Claim** is any pre-service Claim for benefits for Medical Care or treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment.
2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining Medical Care.
3. **Post-Service Claim** is notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which Blue Cross and Blue Shield may request in connection with services rendered to you.

#### Urgent Care Clinical Claims\*

Type of Notice or Extension	Timing
If your Claim is incomplete, Blue Cross and Blue Shield must notify you within:	24 hours**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to Blue Cross and Blue Shield within:	48 hours after receiving notice

Blue Cross and Blue Shield must notify you of the Claim determination (whether adverse or not):

If the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	48 hours
after receiving the completed Claim (if the initial Claim is incomplete), within:	24 hours of receipt of completed Claim

\* You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call Blue Cross and Blue Shield at the toll-free number listed on the back of your identification card as soon as possible to submit an Urgent Care Clinical Claim.

\*\* Notification may be oral unless the Claimant requests written notification.

### Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, Blue Cross and Blue Shield must notify you within:	5 days*
If your Claim is incomplete, Blue Cross and Blue Shield must notify you within:	15 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to Blue Cross and Blue Shield within:	45 days after receiving notice
Blue Cross and Blue Shield must notify you of the Claim determination (whether adverse or not):	
If the initial Claim is complete, within:	15 days**
after receiving the completed Claim (if the initial Claim is incomplete), within:	30 days
If you require post-stabilization care after an Emergency within:	The time appropriate to the circumstance not to exceed one hour after the time of request

\* Notification may be oral unless the Claimant requests written notification.

\*\* This period may be extended one time by Blue Cross and Blue Shield for up to 15 days, provided that Blue Cross and Blue Shield both (1) determines that such an extension is necessary due to matters beyond the control of Blue Cross and Blue Shield and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Blue Cross and Blue Shield expects to render a decision.

### Post-Service Claims

Type of Notice or Extension	Timing
If your Claim is incomplete, Blue Cross and Blue Shield must notify you within:	30 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to Blue Cross and Blue Shield within:	45 days after receiving notice
Blue Cross and Blue Shield must notify you of any adverse Claim determination:	
If the initial Claim is complete, within:	30 days*
after receiving the completed Claim (if the initial Claim is incomplete), within:	45 days

\* This period may be extended one time by Blue Cross and Blue Shield for up to 15 days, provided that Blue Cross and Blue Shield both (1) determines that such an extension is necessary due to matters beyond the control of Blue Cross and Blue Shield and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which Blue Cross and Blue Shield expects to render a decision.

### Concurrent Care

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For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

## **CLAIM APPEAL PROCEDURES**

### **Claim Appeal Procedures - Definitions**

An “Adverse Benefit Determination” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide in response to a Claim, Pre-Service Claim or Urgent Care Clinical Claim 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 and Blue Cross and Blue Shield reduces or terminates such treatment (other than by amendment or termination of the benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium. Please refer to the provision entitled “Rescission of Coverage” in the *Eligibility and Premium Information* section of this Policy for additional information.

In addition, an Adverse Benefit Determination, also includes an “Adverse Determination.” An “Adverse Determination” means:

1. a determination by Blue Cross and Blue Shield or its designated utilization review organization that, based upon the information provided, a request for a benefit under Blue Cross and Blue Shield's health benefit plan upon application of any utilization review technique does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or it is determined to be Experimental or Investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; or
2. the denial, reduction, or termination of 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
3. a Rescission of coverage. Please refer to the provision entitled “Rescission of Coverage” in the *Eligibility and Premium Information* section of this Policy for additional information.

### **Expedited Clinical Appeals**

If your situation meets the definition of an expedited Clinical Appeal, you may be entitled to an appeal on an expedited basis. An expedited Clinical Appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, that if a decision is denied, may significantly increase the risk to your health, as well as continued Hospitalization. Before authorization of benefits for an Ongoing Course of Treatment is terminated or reduced, Blue Cross and Blue Shield will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the Ongoing Course of Treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent Clinical Appeal, Blue Cross and Blue Shield will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Blue Cross and Blue Shield will render a decision on the appeal within 24 hours after it receives the requested information, but in no event more than 48 hours after the appeal has been received by Blue Cross and Blue Shield.

### **How to Appeal an Adverse Benefit Determination**

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You have the right to seek and obtain a review of any determination of a Claim, any determination of a request for preauthorization, or any other determination made by Blue Cross and Blue Shield in accordance with the benefits and procedures detailed in your health benefit plan.

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

If you believe Blue Cross and Blue Shield incorrectly denied all or part of your benefits, you may have your Claim reviewed. Blue Cross and Blue Shield will review its decision in accordance with the following procedure:

1. Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to Blue Cross and Blue Shield to request a Claim review. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the Adverse Benefit Determination.
2. In support of your Claim review, you have the option of presenting evidence and testimony to Blue Cross and Blue Shield. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.
3. To contact Blue Cross and Blue Shield to request a Claim review or appeal an Adverse Benefit Determination, use the following contact information:

Blue Cross and Blue Shield of Illinois  
P.O. Box 660603  
Dallas, TX 75266-0603  
(800) 538-8833 Toll-free number  
(866) 414-4258 Fax number  
(918) 551-2011 Fax number

for Urgent requests send a secure email by using our message center by logging into  
Blue Access for Members<sup>SM</sup> (BAM)  
at [www.bcbsil.com](http://www.bcbsil.com)

During the course of your internal appeal(s), Blue Cross and Blue Shield will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by Blue Cross and Blue Shield in connection with the appealed Claim, as well as any new or additional rationale for denial at the internal appeals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. Blue Cross and Blue Shield may extend the time period described in this Policy for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with Blue Cross and Blue Shield and/or by external advisors, but who were not involved in making the initial denial of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the Claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by Blue Cross and Blue Shield.

### **Timing of Non-Urgent Appeal Determinations**

Upon receipt of a non-urgent concurrent pre-service or post-service appeal, Blue Cross and Blue Shield will notify the party filing the appeal within three business days of all the information needed to review the appeal.

Blue Cross and Blue Shield will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 15 business days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 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.

### **Notice of Appeal Determination**

Blue Cross and Blue Shield will notify the party filing the appeal, you, and, if a Clinical Appeal, any health care Provider who recommended the services involved in the appeal.

The written notice to you or your authorized representative will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based and 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 codes with their meanings and the standards used are also available;
4. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal and external appeal. 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 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 d. below), and your Claim was denied for one of these reasons:
    - i. A decision about the medical need for or the Experimental status of a recommended treatment; or
    - ii. Your health care coverage was rescinded. For additional information, see the definition of Rescission in the *Definitions Section* of this Policy.

To ask for an external review, complete the Request for External Review form that will be provided to you as part of this notice and available at [insurance.illinois.gov/external\\_review](http://insurance.illinois.gov/external_review) and submit it to Department of Insurance at the address shown below for external reviews;

- c. An explanation that you may ask for an expedited (urgent) external review if:
  - i. Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health or ability to regain maximum function;
  - ii. Blue Cross and Blue Shield failed to give you a decision within 48 hours of your request for an expedited appeal;
  - iii. 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; or
  - iv. The Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the Enrollee received Emergency Services, but has not been discharged from a facility;

- d. 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. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative;
- 6. In certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- 7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield;
- 8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits;
- 9. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- 10. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- 11. A description of the standard that was used in denying the Claim and a discussion of the decision; and
- 12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;
- 13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review;
- 14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a Provider appeal;
- 15. The number of levels of appeals available (no more than two levels for group and one level for individual) under the plan and the level of appeal applicable to the adverse determination within the notice;
- 16. A Request for External Review Form, Authorized Representative Form, (HCP) Health Care Provider Certification
- 17. Request for Expedited Review Form, and (HCP) Health Care Provider Certification; and
- 18. Experimental/Investigational Review Form
- 19. 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

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Blue Cross and Blue Shield of Illinois, a Division of  
 Health Care Service Corporation, A Mutual Legal  
 Reserve Company, an Independent Licensee of  
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(217) 558-2083 Fax number  
DOI.complaints@illinois.gov Email address  
<https://mc.insurance.illinois.gov/messagecenter.nsf>

For external review requests:

Illinois Department of Insurance  
Office of Consumer Health Insurance  
External Review Unit  
320 West Washington Street 4th Floor  
Springfield, IL 62767  
(877) 850-4740 Toll-free phone  
(217) 557-8495 Fax number  
DOI.externalreview@illinois.gov Email address  
<https://mc.insurance.illinois.gov/messagecenter.nsf>

If Blue Cross and Blue Shield's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your Claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the "Independent External Review" provision below.

You may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify Blue Cross and Blue Shield of the Complaint. Blue Cross and Blue Shield will have 21 days to respond to the Illinois Department of Insurance.

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

For Complaints, the Illinois Department of Insurance can be contacted at:

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

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

### **If You Need Assistance**

If you have any questions about the Claims procedures or the review procedure, write or call the Blue Cross and Blue Shield Headquarters at 1-800-538-8833. Blue Cross and Blue Shield's offices are open from 8:45 a.m. to 4:45 p.m. Monday through Friday. Customer service hours and operations are subject to change without notice.

Blue Cross and Blue Shield of Illinois  
P.O. Box 660603  
Dallas, TX 75266-0603  
(800) 538-8833 Toll-free phone

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If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9432, or call the number on the back of your identification card for contact information.

## **INDEPENDENT EXTERNAL REVIEW**

You or your authorized representative may make a request for a standard external review or expedited external review of an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

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

### **1. Standard External Review**

You or your authorized representative must submit a written request for a standard external independent review to the Illinois Department of Insurance (“IDOI”) within 4 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  
320 West Washington Street 4th Floor  
Springfield, Illinois 62767  
(877) 850-4740 Toll-free phone  
(217) 557-8495 Fax number  
[DOI.externalreview@illinois.gov](mailto:DOI.externalreview@illinois.gov) Email address  
<https://mc.insurance.illinois.gov/messagecenter.nsf>

You may submit additional information or documentation to support your request for the health care services. Within one business day after the date of receipt of the request, the IDOI will send a copy of the request to Blue Cross and Blue Shield.

### **2. Preliminary Review.**

Within five business days of receipt of the request from the IDOI, Blue Cross and Blue Shield will complete a preliminary review of your request to determine whether:

- a. You were an Enrollee at the time health care service was requested or provided;
- b. 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 has determined that the health care service is not covered;
- c. You have exhausted Blue Cross and Blue Shield's internal appeal process, unless you are not required to exhaust Blue Cross and Blue Shield's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and
- d. You have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being Experimental or Investigational, Blue Cross and Blue Shield 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'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, your health care Provider has certified that one of the following situations is applicable:

- a. Standard health care services or treatments have not been effective in improving your condition;

- b. Standard health care services or treatments are not medically appropriate for you; or
  - c. There is no available standard health care services or treatment covered by Blue Cross and Blue Shield that is more beneficial than the recommended or requested service or treatment.
  - d. In addition, a) your health care Provider has certified in writing that the health care service or treatment is likely to be more beneficial to you, in the opinion of your health care Provider, than any available standard health care services or treatments; or b) your health care Provider, who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat your condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.
3. **Notification.** Within one business day after completion of the preliminary review, Blue Cross and Blue Shield shall notify the IDOI, you and your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the IDOI, you and your authorized representative shall be notified by Blue Cross and Blue Shield in writing of what materials are required to make the request complete or the reason for its ineligibility. Blue Cross and Blue Shield'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 external review and require that it be referred for external review. In making such determination, the IDOI's decision shall be in accordance with the terms of your benefit program (unless such terms are inconsistent with applicable laws) and shall be subject to all applicable laws.
4. **Assignment of IRO.** When the IDOI receives notice that your request is eligible for external review following the preliminary review, the IDOI will, within one business day after the receipt of the notice, a) assign an IRO on a random basis from those IROs approved by the IDOI; and (b) notify Blue Cross and Blue Shield, you and your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Within five business days after the date of receipt of the notice provided by the IDOI of assignment of an IRO, Blue Cross and Blue Shield shall provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may, within five 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 five business days. If Blue Cross and Blue Shield or its designated utilization review organization does not provide the documents and information within five 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 or designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the external review. Within one business day after making the decision to end the external review, the IRO shall notify Blue Cross and Blue Shield, you and, if applicable, your authorized representative, of its decision to reverse the determination.

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

5. **IRO's Decision.** In addition to the documents and information provided by Blue Cross and Blue Shield and you, or if applicable, your authorized representative, the IRO shall also consider the following information if available and appropriate:
- a. Your pertinent medical records;
  - b. Your health care Provider's recommendation;
  - c. Consulting reports from appropriate health care Providers and other documents submitted to Blue Cross and Blue Shield or its designated utilization review organization, you, your authorized representative or your treating Provider;
  - d. The terms of coverage under the benefit program;
  - e. 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;
  - f. Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield or its designated utilization review organization; and
  - g. The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

Within one business day after the receipt of notice of assignment to conduct an external review with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is Experimental or Investigational, the IRO will select one or more clinical reviewers, as it determines is appropriate, to conduct the external review, which clinical reviewers must meet the minimum qualifications set forth in the Illinois Health Carrier External Review Act, and neither you, your authorized representative, if applicable, nor Blue Cross and Blue Shield will choose or control the choice of the Physicians or other health care professionals to be selected to conduct the external review. Each clinical reviewer will provide a written opinion to the IRO within 20 days after being selected by the IRO to conduct the external review on whether the recommended or requested health care service or treatment should be covered.

The IRO will make a decision within 20 days after the date it receives the opinion of each clinical reviewer, which will be determined by the recommendation of a majority of the clinical reviewers.

Within five days after the date of receipt of the necessary information, but in no event more than 45 days after the date of receipt of request for an external review, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the IDOI, Blue Cross and Blue Shield, you and your authorized representative, if applicable, of its decision.

With respect to Experimental or Investigational services or treatments, the IRO will make a decision within 20 days after the date it receives the opinion of each clinical reviewer, which will be determined by the recommendation of a majority of the clinical reviewers.

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 the IDOI;
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 or, in the case of external reviews of Experimental or Investigational services or treatments, the written opinion of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

5. The date of its decisions;
6. The principal reason or reasons for its decision, including what applicable, if any, evidence - based standards that were a basis for its decision; and
7. The rationale for its decision.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield 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.

The IRO is not bound by any Claim determinations reached prior to the submission of information to the IRO. The IDOI, you, your authorized representative, if applicable, and Blue Cross and Blue Shield will receive written notice from the IRO. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance's Office of Consumer Health Insurance.

#### **Standard External Review**

<b>Standard External Review</b>	<b>Timing</b>
If you receive an Adverse Determination or a Final Adverse Determination, you may file a request for an external review within:	4 months after receipt of notice
Blue Cross and Blue Shield shall complete a preliminary review of the request within:	5 business days after receiving request
Blue Cross and Blue Shield must notify you whether the request is complete and eligible for external review:	
If the request is not complete Blue Cross and Blue Shield shall notify you and include what information or materials are required within:	One business day after the preliminary review
If the request is not eligible for external review, Blue Cross and Blue Shield shall notify you and include the reasons for its ineligibility within:	One business day after the preliminary review
Blue Cross and Blue Shield shall notify the IDOI, you or your authorized representative that a request is eligible for external review within:	One business day after the preliminary review
The IDOI shall assign an independent review organization (IRO) within:	One business day after receipt of the notice
Blue Cross and Blue Shield shall provide to the assigned IRO the documents and any information used in making the Adverse Determination or Final Adverse Determination within:	5 business days of notice of assigned IRO
The IRO shall provide notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination within:	5 days after receipt of all required information from you (but no more than 45 days after the receipt of request for external review)

#### **1. Expedited External Review**

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination; (b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of

care, continued stay or health care service for which you received Emergency Services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of a Final Adverse Determination if Blue Cross and Blue Shield fails to provide a decision on a request for an expedited internal appeal within 48 hours.

### **Medically Necessary Determination**

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

Note: If benefits for Mental Illness or Substance Use Disorders are denied on the grounds that they are not Medically Necessary, you may request an expedited external review.

You may also request an expedited external review if a Final Adverse Determination concerns a denial of coverage based on the determination that the treatment or service in question is considered Experimental or Investigational and your health care Provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

Expedited external review will not be provided for retrospective adverse or final adverse determinations.

Your request for an expedited independent external review may be submitted to the IDOI either orally (by calling 877 - 850 - 4740) or in writing as set forth above for requests for standard external review.

2. **Notification.** Upon receipt of a request for an expedited external review, the IDOI shall immediately send a copy of the request to Blue Cross and Blue Shield. Blue Cross and Blue Shield shall immediately notify the IDOI, you and your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review. Blue Cross and Blue Shield'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 (unless such terms are inconsistent with applicable law) and shall be subject to all applicable laws.

3. **Assignment of IRO.** If your request is eligible for expedited external review, the IDOI shall immediately assign an IRO on a random basis from the list of IROs approved by the IDOI; and immediately notify Blue Cross and Blue Shield of the name of the IRO.

Upon receipt from the IDOI of the name of the IRO assigned to conduct the external review, Blue Cross and Blue Shield or its designated utilization review organization shall immediately, (but in no case more than 24 hours after receiving such notice) provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may submit additional information in writing to the assigned IRO, within 24 hours or additional information may accompany the request for an expedited independent external review. If Blue Cross and Blue Shield 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 one business day after making the decision to end the external review, the IRO shall notify the IDOI, Blue Cross and Blue Shield, you and, if applicable, your authorized representative, of its decision to reverse the determination.

As expeditiously as your medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited external review), the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the IDOI, Blue Cross and Blue Shield, you and, if applicable, your authorized representative. If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the IDOI, Blue Cross and Blue Shield and, if applicable, your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of Experimental or Investigational treatments, each clinical reviewer shall provide an opinion orally or in writing to the assigned IRO as expeditiously as your medical condition or circumstances requires, but in no event more than five calendar days after being selected. Within 48 hours after the date it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing to the IDOI, Blue Cross and Blue Shield, you and your authorized representative, if applicable.

If the IRO's initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the IDOI, Blue Cross and Blue Shield and, if applicable, your authorized representative.

The assigned IRO is not bound by any decisions or conclusions reached during Blue Cross and Blue Shield's utilization review process or Blue Cross and Blue Shield's internal appeal process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield 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. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance's Office of Consumer Health Insurance.

An external review decision is binding on Blue Cross and Blue Shield. An external review decision is binding on you, except to the extent you have other remedies available under applicable federal or state law. You and your authorized representative may not file a subsequent request for external review involving the same Adverse Determination or Final Adverse Determination for which you have already received an external review decision.

#### **Expedited External Review**

<b>Expedited External Review</b>	<b>Timing</b>
You may file a request for an expedited external review after the date of receipt of a notice prior to Final Adverse Determination:	Immediately
You may file a request for an expedited external review if Blue Cross and Blue Shield fails to provide a decision on a request for an expedited internal appeal within:	48 hours
Blue Cross and Blue Shield must immediately notify the IDOI, you or your authorized representative whether the request is complete and eligible for an expedited external review or is ineligible for review and may be appealed to the IDOI. The IDOI may make a determination that the request is eligible for an expedited external review, notwithstanding Blue Cross and Blue Shield's determination.	
The IDOI shall assign an independent review organization (IRO):	Immediately
Blue Cross and Blue Shield shall provide all necessary documents and information to the IRO:	Immediately, but not more than 24 hours after assignment of an IRO

If Blue Cross and Blue Shield fails to provide the necessary documents and information within the required time mentioned above, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination.

The IRO shall provide notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination to Blue Cross and Blue Shield, the IDOI, you or your authorized representative:	As expeditiously as your medical condition or circumstances require, but no more than 72 hours after the receipt of request.
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### External Review of Experimental or Investigational Treatment

<b>Experimental or Investigational Treatment External Review</b>	<b>Timing</b>
You may file a request with the IDOI for an external review after receipt of an Adverse Determination or a Final Adverse Determination within:	4 months after date of receipt
<i>If your treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may make an oral request for an expedited external review, after which the IDOI shall immediately notify Blue Cross and Blue Shield and the time frames otherwise applicable to Expedited External Review shall apply.</i>	
After the receipt for an external review, the IDOI shall send a copy of the request to Blue Cross and Blue Shield within:	One business day
Blue Cross and Blue Shield shall complete a preliminary review of the request within:	5 business days
After completion of the preliminary review, Blue Cross and Blue Shield shall notify you or your authorized representative and the IDOI whether the request is complete and eligible for external review within:	One business day
<i>When the IDOI receives notice that the request is eligible for external review, the IDOI shall:</i>	
assign an IRO and notify Blue Cross and Blue Shield of the name of the IRO, within:	One business day
notify you or your authorized representative in writing of the request's eligibility and acceptance for external review and the name of the IRO, within:	One business day
If you are notified that your request for an external review has been accepted, you or your authorized representative may submit additional information to the assigned IRO within:	5 business days
The assigned IRO shall then select one or more clinical reviewers within:	One business day
Blue Cross and Blue Shield shall provide to the assigned IRO the documents and any information used in making the Adverse Determination or Final Adverse Determination within:	5 business days of notice of assigned IRO
After being selected by the assigned IRO, each clinical reviewer shall provide an opinion to the assigned IRO on whether the recommended or requested health care service shall be covered within:	20 days
or, in the case of an expedited external review:	Immediately, but in no event more than 5 calendar days

The assigned IRO shall make a decision after receipt of the opinion from each clinical reviewer and provide notification of the decision to the IDOI, you or your authorized representative and Blue Cross and Blue Shield within:	20 days
or, in the case of an expedited external review, within:	48 hours after receipt of the opinion of each clinical reviewer

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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

## OTHER THINGS YOU SHOULD KNOW

### THIRD PARTY RECOVERY

**Blue Cross and Blue Shield is assigned the right to recover for a sickness or injury from a third party, or his/her insurer, only to the extent of the benefits paid by Blue Cross and Blue Shield for such sickness or injury.**

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

### BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield has contracts with certain Providers and other suppliers of goods and services for the provision of and/or payment for health care goods and services to all persons entitled to health care benefits under individual and group policies or contracts to which Blue Cross and Blue Shield is a party.

Under certain circumstances described in its contracts with such Providers and suppliers, Blue Cross and Blue Shield may:

1. Receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which Blue Cross and Blue Shield was obligated to pay the Provider or supplier;
2. Pay Providers or suppliers substantially less than their Claim Charges for goods or services, by discount or otherwise; or
3. Receive from Providers or suppliers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Policy and the calculation of all required deductible and Coinsurance amounts payable by you under this Policy shall be based on the Provider's Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of this Policy. You are not entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Providers work, please consider the following example:

1. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is \$1,000. How is the \$1,000 bill paid?
2. You personally will have to pay the deductible and Coinsurance amounts set out in your Policy.
3. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Provider's Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the \$1,000 Hospital bill would be reduced by 30% to \$700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.
4. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the \$1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of \$700, or \$140. You should note that your 20% Coinsurance is based on the full \$1,000 Hospital bill, after it is reduced by the applicable ADP.
5. After taking into account the deductible and Coinsurance amounts, Blue Cross and Blue Shield will satisfy its portion of the Hospital bill. In most cases, Blue Cross and Blue Shield has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money Blue Cross and Blue Shield would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is \$1,000, your deductible has already been satisfied, and your Coinsurance is \$140, then Blue Cross and Blue Shield has to satisfy the rest of the Hospital bill, or \$860. Blue Cross and Blue Shield will usually be able to satisfy the \$860 bill that remains after your Coinsurance and deductible, by paying less than \$860 to the Hospital, often substantially less than \$860. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the \$860 bill and whatever Blue Cross and Blue Shield ultimately pays under its contracts with Providers, and you are not entitled to any part of these savings.

Blue Cross and Blue Shield may receive such payments, discounts, and/or other allowances during the term of this Policy.

You are not entitled to receive any portion of any such payments, discounts, and/or other allowances. Any Copayments and/or deductibles payable by you are pre-determined fixed amounts, based upon the selected benefit plan, which are not impacted by any discounts or contractual allowances which Blue Cross and Blue Shield may receive from a Provider.

## **OTHER BLUE CROSS AND BLUE SHIELD PLANS' SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS**

### **Out-of-Area Services**

Blue Cross and Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans under their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Arrangements".

These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you obtain health care services outside of the Blue Cross and Blue Shield of Illinois service area , the Claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside the service area, you will receive it from one of two kinds of healthcare Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") do not contract with the Host Blue. Blue Cross and Blue Shield of Illinois' payment practices in both instances are described below.

### **BlueCard® Program**

Under BlueCard Program, when you obtain Out-of-Area Covered Health Care Services, as defined above, from a health care Provider participating with a Host Blue, Blue Cross and Blue Shield will remain responsible for fulfilling Blue Cross and Blue Shield contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Health Care Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating Provider will automatically file a Claim for the Out-of-Area Covered Health Care Services provided to you, so there are no Claim forms for you to fill out. You will be responsible for the Copayment or Coinsurance amount, as stated in this Policy.

### **Emergency Care Services:**

If you experience a medical emergency while traveling outside of the Blue Cross and Blue Shield of Illinois' Service Area, Go to the nearest emergency facility, urgent care facility, or other health care provider.

Whenever you receive Out-of-Area Covered Health Care Services outside of the Blue Cross and Blue Shield of Illinois' service area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

1. The billed charges for your Covered Services, or
2. The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Illinois.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges.

Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield uses for your Claim because they will not be applied retroactively to Claims already paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to your liability calculation. If applicable, Blue Cross and Blue Shield of Illinois will include any such surcharge, tax or other fee as part of the Claim Charge passed on to you. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Service according to applicable law.

## **Non-Participating Providers Outside Blue Cross and Blue Shield of Illinois Service Area**

### **1. Liability Calculation**

When Covered Services are provided outside of Blue Cross and Blue Shield of Illinois service area by Non-Participating Providers, the amount you pay for such services will generally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Blue Cross and Blue Shield of Illinois will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

### **2. Exceptions**

In certain situations, Blue Cross and Blue Shield of Illinois may use other payment bases to determine the amount Blue Cross and Blue Shield of Illinois will pay for services rendered by Non-Participating healthcare Providers. If a negotiated payment is not available, then Blue Cross and Blue Shield of Illinois may make a payment based on the lesser of: the amount calculated using the methodology described in the Policy for Non-Participating Providers located inside our service area (and described in Section C(a)(1) above); or the following such as: (i) billed covered charges; (ii) the payment we would make if the healthcare services had been obtained within our service area; or (iii) a special negotiated payment, to determine the amount Blue Cross and Blue Shield of Illinois will pay for services rendered by Non-Participating Providers; or (iv) for professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable; or (v) for Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs; that hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility. In these situations, you may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Blue Cross and Blue Shield of Illinois will make for the Covered Services as set forth in this paragraph.

## **Blue Cross Blue Shield Global Core**

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, 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 United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the service center at 1-800-810-BLUE (2583) or

call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or Hospitalization, if necessary.

## **1. Inpatient Services**

In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your deductible, Copayment and/or Coinsurance amount, if applicable. In such cases, the Hospital will submit your Claims to the service center to begin Claim processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services.

## **2. Outpatient Services**

Physicians, urgent care centers and other Outpatient Providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands 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 Blue Cross Blue Shield Global Core International Claim form and send the Claim form and the Provider's itemized bill(s) to the service center (the address is on the form) to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from Blue Cross and Blue Shield of Illinois, the service center or online at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com). If you need assistance with your Claim submission, you should call service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

### **BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS**

#### **Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers**

Blue Cross and Blue Shield hereby informs you that it has arrangements with Prescription Drug Providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Policy. Under its arrangements with Participating Prescription Drug Providers, Blue Cross and Blue Shield may receive from these Providers discounts for prescription drugs dispensed to you. You are not entitled to receive any portion of any such payments, discounts and/or other allowances.

Coinurance amounts payable by you under this Policy will be calculated on the basis of the Provider's Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider and Blue Cross and Blue Shield for a prescription drug, whichever is lower.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

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

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

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

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

Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 5.5% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of the Plan and other Blue Plan operating divisions.

### **Blue Cross and Blue Shield's Separate Financial Arrangements with Pharmacy Benefit Managers**

Blue Cross and Blue Shield owns a significant portion of the equity of Prime Therapeutics LLC and informs you that Blue Cross and Blue Shield has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on Blue Cross and Blue Shield's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with Blue Cross and Blue Shield. You are not entitled to receive any portion of such rebates except to the extent they may be as they are figured into the pricing of the product.

### **PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS**

All benefit payments may be made by Blue Cross and Blue Shield directly to any Provider furnishing the Covered Services for which such payment is due, and Blue Cross and Blue Shield is authorized by you to make such payments directly to such Providers. However, Blue Cross and Blue Shield reserves the right to pay any benefits that are payable under the terms of this Policy directly to you, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by Blue Cross and Blue Shield sufficiently in advance of Blue Cross and Blue Shield's benefit payment. Blue Cross and Blue Shield reserves the right to require submission of a copy of the Assignment of Benefit Payment.

Under this Policy, Blue Cross and Blue Shield of Illinois has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, Blue Cross and Blue Shield of Illinois may pay benefits to you if you receive Covered Services from a Non-Participating Provider. Blue Cross and Blue Shield of Illinois is specifically authorized by you to determine to whom any benefit payment should be made. Once Covered Services are rendered by a Provider, you have no right to request that Blue Cross and Blue Shield not pay the Claim submitted by such Provider and no such request will be given effect. In addition, Blue Cross and Blue Shield will have no liability to you or any other person because of its rejection of such request.

Except for the assignment of benefit payment described above, neither this Policy nor an Enrollee's Claim for payment of benefits under this Policy is assignable in whole or in part to any person or entity at any time, and coverage under this Policy is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage.

## **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS**

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Illinois law, if there is a conflict between the terms of this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section and the terms in the rest of this Certificate, the terms of this section will apply. However, definitions set forth in the **FEDERAL NO SURPRISES ACT DEFINITIONS** provision of this section are for purposes of this section only.

### **1. PCP Selection**

The Plan requires the designation of a Primary Care Provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family Members.

Until you make this designation, Blue Cross and Blue Shield of Illinois designates one for you. For information on how to select a PCP and for a list of the participating PCPs, contact BCBSIL at [www.bcbsil.com](http://www.bcbsil.com) or customer service at the toll-free number on the back of your identification card.

For Dependent children, you may designate any Participating Provider who specializes in pediatric care as their Primary Care Provider (PCP).

### **2. OB/GYN Care**

You are not required to obtain a referral or authorization from your Primary Care Provider before obtaining Covered Services from any Participating Provider specializing in obstetrics or gynecology. However, before obtaining Covered obstetrical or gynecological care, the Provider must comply with certain policies and procedures required by your Plan, including Prior Authorization and referral policies. For a list of Participating Providers who specialize in obstetrics or gynecology, visit [www.bcbsil.com](http://www.bcbsil.com) or contact customer service at the toll-free number on the back of your identification card.

### **3. Continuity of Care**

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

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

- e. You are determined to be terminally ill.

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

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

#### **4. Federal No Surprises Act Definitions**

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

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

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

**"Emergency Services"** means, for purposes of this section only,

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

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

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

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

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

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

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

## **5. Federal No Surprises Act Surprise Billing Protections**

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

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

### **Claim Payments**

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider. Additionally, under Illinois law, in the event there is a payment dispute between the Non-Participating Provider and BCBSIL and attempts to negotiate a payment resolution are unsuccessful, the Non-Participating Provider or BCBSIL may initiate binding arbitration.

### **Cost-Sharing**

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

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

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

## **6. Federal No Surprises Act Prohibition of Balance Billing**

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

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

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

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

## **OUT-OF-POCKET EXPENSE LIMITATION**

If, during any calendar year, you have paid Copayments, deductibles and/or any Coinsurance amount for Covered Services under this Policy the total amount of which equals the amount shown on your Schedule Page, your benefits for any additional Covered Services that you may receive during that calendar year, including any Copayment, deductible and/or Coinsurance amounts, will be reimbursed by Blue Cross and Blue Shield. Should the federal government adjust the deductible and/or out-of-pocket expense limit amount(s) for high deductible health plans, the deductible and/or the out-of-pocket expense limit amount(s) in this Policy will be adjusted accordingly.

In the event your Physician or the Hospital requires you to pay any additional Copayments, deductible and/or Coinsurance amounts after you have met the above provision, upon receipt of properly authenticated documentation, Blue Cross and Blue Shield will reimburse to you, the amount of those Copayments, deductibles and/or Coinsurance amounts.

The above "Out-of-Pocket expense limitation" provision does not include the following:

1. Services, supplies or charges limited or excluded under this Policy; and
2. Expenses not covered because a benefit maximum has been reached; and
3. Prohibited Third Party Cost Sharing Payments.

## **YOUR PROVIDER RELATIONSHIPS**

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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

The choice of a Hospital, Primary Care Physician or any other Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.

Blue Cross and Blue Shield does not itself undertake to provide health care services, but solely to arrange for the provision of health care services and to make payments to Providers for the Covered Services received by you. Blue Cross and Blue Shield of Illinois is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by Blue Cross and Blue Shield of Illinois. Any contractual relationship between a Physician and a Hospital or other Provider should not be construed to mean that Blue Cross and Blue Shield is providing professional service.

## **ENTIRE POLICY**

This Policy, including any Addenda and/or the application(s) for this Policy, if any, of the Enrollees constitutes the entire contract of coverage between you and Blue Cross and Blue Shield. No change in this Policy shall be valid until approved by an executive office of Blue Cross and Blue Shield and unless such approval be endorsed here on or attached hereto.

## **POLICY YEAR**

Policy Year means the 12 month period beginning on January 1 of each year.

## **PREMIUM REBATES, AND PREMIUM ABATEMENTS; AND COST-SHARING**

1. 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 directly provide any rebate owed participants or former participants to such persons in amounts as required by law.
2. Abatement. Blue Cross and Blue Shield may from time to time determine to abate (all or some of) the premium due under this Policy for particular period(s).
3. 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.
4. 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 participant or former participant (if applicable) 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.
5. Cost-Sharing. Blue Cross and Blue Shield reserves the right from time to time to waive or reduce the Coinsurance, Copayments and/or deductibles under this Policy.

## **AGENCY RELATIONSHIPS**

If this Policy is purchased through the Exchange, in no event shall Blue Cross and Blue Shield be considered the agent of the Exchange or be responsible for the Exchange. All information you provide to the Exchange and received by Blue Cross and Blue Shield from the Exchange will be relied upon as accurate and complete. You must promptly notify the Exchange and Blue Cross and Blue Shield of any changes to such information.

## **NOTICES**

Any information or notice which you furnish to Blue Cross and Blue Shield under this Policy must be in writing and sent to Blue Cross and Blue Shield at its offices at 300 East Randolph Street, Chicago, Illinois, 60601-5099 (unless another address has been stated in this Policy for a specific situation). Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield's records and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue

Cross and Blue Shield's records. Blue Cross and Blue Shield may also provide such notices electronically, to the extent permitted by applicable law.

## **CONTINUITY OF CARE**

If you are under the care of a Primary Care Provider or other Provider who leaves the Plan's network (for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by State licensing board), and your Provider agrees, you may be able to continue receiving Covered Services with that Provider for the following:

1. An Ongoing Course of Treatment for a serious acute disease or condition requiring complex ongoing care that you are currently receiving (for example, you are currently receiving, such as Chemotherapy, Radiation Therapy, or post-operative visits for a serious acute disease or condition);
2. An Ongoing Course of Treatment for a Life-Threatening Disease Or Condition and the likelihood of death is probable unless the course of the disease or condition is interrupted;
3. An Ongoing Course of Treatment for the second and third trimester of pregnancy through the postpartum period; or
4. An Ongoing Course of Treatment for a health condition of which a treating Provider attests that discontinuing care by the Provider who is terminating from the network would worsen the condition or interfere with anticipated outcomes.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than ninety (90) days beyond the date from the date of the notice to the Enrollee of the Provider's termination from the network plan, or if the Enrollee has entered the second or third trimester of pregnancy at the time of the Provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery.

If you are a new MyBlue Plus POS Enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy, and your Physician does not belong to the Blue Cross and Blue Shield network, but is within Blue Cross and Blue Shield's service area, you may request the option of transition of care benefits. You must submit a written request to Blue Cross and Blue Shield for transition of care benefits within 15 business days of your eligibility effective date, or if you have entered the second or third trimester of pregnancy at the time of the Provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery. Blue Cross and Blue Shield may authorize transition of care benefits for a period up to 90 days from the effective date of enrollment. Authorization of benefits is dependent on the Physician's agreement to contractual requirements and submission of a detailed treatment plan. A written notice of Blue Cross and Blue Shield's determination will be sent to you within 15 business days of receipt of your request.

You have the right to appeal any decision made for a request for benefits under this provision as explained in the "Claim Appeal Procedures" provision in the *How To File A Claim* section of this Policy.

## **LIMITATIONS OF ACTIONS**

No legal action may be brought to recover under this Policy until at least 60 days have elapsed since a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Policy. In addition, no such action may be brought once 3 years have elapsed from the date that a Claim is required to be furnished to Blue Cross and Blue Shield in accordance with the requirements of this Policy.

## **VALUE BASED DESIGN PROGRAMS**

The Claim Administrator and your Employer has the right to offer medical behavior wellness, incentive, maintenance, or improvement programs that allows for a reward, a contribution, a penalty, a deferential in premiums or a differential in medical, prescription drug or equipment Copayments, Coinsurance, deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by Blue Cross and Blue Shield or an entity chosen by Blue Cross and Blue Shield to administer such programs. In addition, discount programs for various

health and wellness-related or insurance-related items and services may be available from time to time. Such programs may be discontinued without notice.

For individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, Blue Cross and Blue Shield will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards. Contact Blue Cross and Blue Shield for additional information regarding any value based programs offered by Blue Cross and Blue Shield.

Blue Cross and Blue Shield makes available at no additional cost to your, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by Blue Cross and Blue Shield's designated outside vendor and acceptance or declination of these services is optional to Members. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at [www.bcbsil.com](http://www.bcbsil.com) or telephonically by calling the toll-free telephone number on your identification card. Services may automatically end when the person is no longer an eligible Member. Services may change or be discontinued at any time with or without notice and Blue Cross and Blue Shield 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.

## **SERVICE MARK REGULATION**

You hereby acknowledge your understanding that this Policy constitutes a contract solely between you and Blue Cross and Blue Shield, that Blue Cross and Blue Shield is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting us to use the Blue Cross and Blue Shield Service Mark in the State of Illinois, and that we are not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this Policy based upon representations by any person other than Blue Cross and Blue Shield and that no person, entity, or organization other than Blue Cross and Blue Shield shall be held accountable or liable to you for any of our obligations to you created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield other than those obligations created under other provisions of this Policy.

## **PHYSICAL EXAMINATION AND AUTOPSY**

Blue Cross and Blue Shield shall, at its own expense, have the right and opportunity to examine the person of an Enrollee when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

## **PROHIBITION AGAINST SUBSTITUTION**

Blue Cross and Blue Shield cannot require you to substitute your Primary Care Physician during any Inpatient Hospital stay, such as with a Hospitalist Physician who is licensed to practice medicine in all its branches without the authorization of your Primary Care Physician.

## **MODIFICATION OF COVERAGE**

Blue Cross and Blue Shield may modify your Policy as required or permitted by applicable law, and may modify your Policy at renewal as long as the modification is consistent with applicable state and federal law on a uniform basis. Should Blue Cross and Blue Shield elect to uniformly modify, terminate or discontinue coverage under this Policy, Blue Cross and Blue Shield must provide 90 days advance notice to the Illinois Department of Insurance.

## **MEDICALLY NECESSARY DISPUTE RESOLUTION**

A dispute resolution process must be established in which a Physician, holding the same class of license as your Primary Care Physician, selected by you in the event of a dispute regarding the medical necessity of a service. Blue Cross and Blue Shield shall be required to provide the services should the reviewing Physician determine services to be Medically Necessary.

## **INFORMATION AND RECORDS**

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Policy, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnification on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield or its agent, and agrees that any such Provider, person, or other entity may furnish to Blue Cross and Blue Shield or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to Providers, other Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish Blue Cross and Blue Shield information regarding you or your dependents becoming eligible for Medicare, termination of Medicare eligibility, or any change in Medicare eligibility status, in order that Blue Cross and Blue Shield be able to make Claim Payments in accordance with MSP laws.

## **QUALIFIED HEALTH PLAN ACTUARIAL VALUE**

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.

## **MEMBER DATA SHARING**

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, by the Host Blues whose service area covers the geographic area in which you reside. As part of the overall plan of benefits that Blue Cross and Blue Shield of Illinois offers to you, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, Blue Cross and Blue Shield of Illinois may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under this Policy you have with Blue Cross and Blue Shield of Illinois to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

## **OVERPAYMENT**

If the Plan pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or was made in error ("Overpayment"), the Plan has the right to a refund from: (i) the person to, or for whom, such benefits were paid, or (ii) any other insurance company or plan, or (iii) any other entity or organization.

If no refund is received, the Plan may deduct any refund due to it from:

1. Any future benefit payment owed to anyone under this Policy, whether for the same or a different member; or,
2. Any future benefit payment owed to anyone under another Plan administered ASO benefit program; or,
3. Any future benefit payment owed to anyone under another Plan insured group benefit plan or individual Policy; or,
4. Any future payment, or other payment, owed to any person or entity; or
5. Any future payment owed to one or more Participating Providers or Non-Participating Providers.

Further, the Plan has the right to reduce your benefit plan or Policy's payment to a Provider by the amount necessary to recover another Plan's or Policy's Overpayment to the same Provider and to remit the recovered amount to the other Plan or Policy.

## **DEFINITIONS**

Throughout this Policy, many words are used which have a specific meaning when applied to your health care coverage. The definitions of these words are listed below in alphabetical order. These defined words will always be capitalized when used in this Policy.

**A1C Testing** – means blood sugar level testing used to diagnose prediabetes, type I diabetes, and type II diabetes, and to monitor management of blood sugar levels.

**Acute Treatment Services** – means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

**Advanced Premium Tax Credit** – means a Premium Tax Credit that has been received by an Enrollee in advance.

**Ambulatory Surgical Facility** – means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services, when operating within the scope of such license.

**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:

1. A federally funded or approved trial;
2. A clinical trial conducted under an FDA Investigational new drug application; or
3. A drug trial that is exempt from the requirement of an FDA Investigational new drug application.

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

**Average Discount Percentage (“ADP”)** – means a percentage discount determined by Blue Cross and Blue Shield that will be applied to a Provider’s Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by Blue Cross and Blue Shield to be relevant to the particular Claim. The ADP reflects Blue Cross and Blue Shield's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this Policy regarding “Blue Cross and Blue Shield’s Separate Financial Arrangements with Providers”) In determining the ADP applicable to a particular Claim, Blue Cross and Blue Shield will take into account differences among Hospitals and other facilities, Blue Cross and Blue Shield contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors.

**Behavioral Health Practitioner** – means a Physician or professional Provider who is duly licensed to render services for the treatment of Mental Illness or Substance Use Disorder Treatment.

**Benefit Period** – means the period beginning on the Coverage Date and ending on the Termination Date, except for the Pediatric Vision Care Benefit Period, which is defined in the *Pediatric Vision Care* section of this Policy.

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

**Certified Clinical Nurse Specialist** – means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and Hospital referral and (c) meets the following qualifications:

1. Is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and
2. Is a graduate of an advanced practice nursing program.

**Certified Nurse Midwife** – means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and Hospital referral and (c) meets the following qualifications:

1. Is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and
2. Is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

**Certified Nurse Practitioner** – means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and Hospital referral and (c) meets the following qualifications:

1. Is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and
2. Is a graduate of an advanced practice nursing program.

**Certified Registered Nurse Anesthetist (CRNA)** – means a person who (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists (and is operating within the scope of such license).

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

**Chiropractor** – means a duly licensed chiropractor.

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

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

**Claim Charge** – means the amount which appears on a Claim as the Provider's or supplier's charge for goods or services furnished to you, without adjustment or reduction and regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider or supplier. (See provisions of this Policy regarding ("Blue Cross and Blue Shield's Separate Financial Arrangements with Providers."))

**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 Provider's Charge for Covered Services rendered to you, 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 Appeal** – means an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care Provider that do not meet the definition of an Urgent/Expedited Clinical Appeal.

**Clinical Stabilization Services** – means 24-hour treatment, usually following Acute Treatment Services for Substance Use Disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others of the member, and aftercare planning for individuals beginning to engage in recovery from addiction.

**COBRA** – means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 P.L. 99-272, as amended which regulate the conditions and manner under which an employer can offer continuation of group health insurance to employees and their family members whose coverage would otherwise terminate under the terms of this Policy.

**Coinsurance** – means a Copayment that is a percentage of an eligible expense that you are required to pay towards a Covered Service.

**Coordinated Home Care Program** – means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.)

**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.

**Continuous Ambulatory Peritoneal Dialysis Treatment** – means a continuous dialysis process using a patient's peritoneal membrane as a dialyzer.

**Copayment** – means a specified dollar amount or Coinsurance that you are required to pay towards a Covered Service.

**Cost-Sharing Reductions** – means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an American Indian/Alaskan Native enrolled in a QHP in the Exchange as described under section 1402 of the Affordable Care Act and 45 C.F.R. § 155.20. Cost-Sharing Reductions are discounts that lower the amount you have to pay out-of-pocket for deductibles, Coinsurance, and Copayments. They also lower your out-of-pocket maximum. The federal government determines if you are eligible for these savings. The federal government also funds the Cost-Sharing Reductions under your Policy.

**Coverage Date** – means the date on which your coverage under this Policy begins.

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

**Custodial Care Service** – means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills or 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.).

**Dentist** – means a duly licensed dentist.

**Diagnostic Service** – means tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, computerized tomography ("CT scans"), magnetic resonance imaging ("MRI") and positron emission tomography ("PET scans").

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

**Domestic Partner** – means a person with whom you have entered into a Domestic Partnership.

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

1. You and your Domestic Partner have lived together for at least six months;
2. Neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner;
3. Both you and your Domestic Partner are at least 18 years of age and mentally competent to consent to contract;
4. You and your Domestic Partner reside together and intend to do so indefinitely;
5. You and your Domestic Partner have an exclusive mutual commitment similar to marriage; and
6. You and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

**Early Acquired Disorder** – means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a 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.

**Electroconvulsive Therapy** – means a medical procedure in which a brief application of an electric stimulus is used to produce a generalized seizure.

**Eligible Charge** – in the case of a Provider, other than a Physician, which has a written agreement with the Plan or another Blue Cross and/or Blue Shield Plan to provide care to participants in the health care plan, or is designated as a participating Provider by any Blue Cross and/or Blue Shield Plan, at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services.

In addition to the foregoing, the Eligible Charge will be subject in all respects to the Plan's Claim Payment rules, edits and methodologies regardless of the Provider's status as a participating Provider or Non-Participating Provider. Please refer to "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers" provision in the *Other Things You Should Know* section of this Policy.

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

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part,
4. Inadequately controlled pain; or
5. With respect to a pregnant woman who is having contractions:
  - a. Inadequate time to complete a safe transfer to another Hospital before delivery; or
  - b. A transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

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

**Emergency Mental Illness or Substance Use Disorder Admission** – means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorders condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

**Emergency Services** – means, with respect to an Enrollee of a health care Plan, transportation services, including but not limited to ambulance services, and covered Inpatient and Outpatient Hospital services furnished by a Provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Condition.

**Enrollee** – means the person who has applied for coverage under this Policy and to whom Blue Cross and Blue Shield has issued an identification card.

**Enrollment Date** – means the first day of coverage under your health plan or, if you have a waiting period prior to the effective date of your coverage, the first day of the waiting period.

**Exchange or Marketplace** – means a governmental agency or non-profit entity that meets the applicable Exchange standards, and other related standards established under applicable law, and makes Qualified Health Plan (QHPs) available to Qualified Individuals and qualified employers (as these terms are defined by applicable law). Unless otherwise identified, the term “Exchange” refers to State Exchanges, regional Exchanges subsidiary Exchanges, and/or a Federally- facilitated Exchange on which Blue Cross and Blue Shield of Illinois offers this QHP. For additional information about the rules and responsibilities of the Exchange, please read the provision entitled “Agency Relationships” in the *Other Things You Should Know* section of this Policy.

**Experimental/Investigational (also referred to as “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;

1. Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
2. Are appropriate for the Hospital or facility in which they were performed; and
3. The Physician or other professional Provider has had the appropriate training and experience to provide the treatment or procedure.

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

**Family Coverage** – means that your application for coverage was for yourself and other eligible members of your family.

**Freestanding Facility** – means an Outpatient services facility that is not covered under a Hospital's written agreement with Blue Cross and Blue Shield and has its own billing number and written agreement with Blue Cross and Blue Shield to provide services to participants in the benefit program at the time services are rendered. Freestanding Facilities may also be referred to as Outpatient Freestanding Facilities.

**Formulary Drug** – means either a brand name prescription drug that has been designated as a preferred drug by Blue Cross and Blue Shield or any generic prescription drug. The listing of drugs designated as being Formulary Drugs may be amended from time to time by Blue Cross and Blue Shield.

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

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

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

**Hospice Care Program** – means a centrally administered program designed to provide physical, psychological, social and spiritual care for terminally ill persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program service is available in the home, or in Inpatient Hospital or Skilled Nursing Facility special hospice care unit.

**Hospice Care Program Provider** – means an organization duly licensed to provide Hospice Care Program service.

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

**In Home Health Assessment** – means Covered Services including, but not limited to, health and blood pressure and blood sugar level screening. The assessment is designed to provide you with information regarding your health that can be discussed with your Primary Care Provider.

**Individual Coverage** – means that your application for coverage was only for yourself.

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

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

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

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

**Intensive Outpatient Program** – means this is a Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder. Requirements: Blue Cross and Blue Shield requires that any Mental Illness and/or Substance Use Disorder Intensive Outpatient Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by the plan.

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

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

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

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

**Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy** – means therapy administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

**Marriage and Family Therapist** – means a duly licensed marriage and family therapist within the scope of such license.

**Medical Care** – means the ordinary and usual professional services rendered by a Physician, Behavioral Health Practitioner, or other specified Provider during a professional visit, for the treatment of an illness or injury.

**Medicare** – means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

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

**Mental Illness** – means a condition or disorder that involves a mental health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders or any mental health condition that occurs during pregnancy or during the postpartum period, including but not limited to, postpartum depression.

**Naprapath** – means a duly licensed naprapath.

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

**Network Service Area** – means the geographic area designated by Blue Cross and Blue Shield of Illinois, within which the Benefits of this Plan are available to Members. This Plan accepts Members if they reside, live or work in the geographic Network Service Area. In addition, routine non-Emergency Services are generally limited to Providers within the service area. A Member may call the Customer Service Department at the number shown on the Identification Card or visit the website at [www.bcbsil.com](http://www.bcbsil.com) to determine if he or she is in the Network Service Area.

**Non-Clinical Appeal** – means an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

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

**Occupational Therapy** – means a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

**Ongoing Course of Treatment** – see provision for “Continuity of Care.”

**Optometrist** – means a duly licensed optometrist.

**Outpatient** – means that you are receiving treatment while not an Inpatient.

**Partial Hospitalization Treatment Program** – means a Hospital's planned therapeutic treatment program, which has been approved by your Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment, in which patients spend days. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an Inpatient unit, i.e. medically supervised by a Physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Participants at this level of care do not require 24 hour supervision and are not considered a resident at the program. Requirements: Blue Cross and Blue Shield requires that any Mental Illness and/or Substance Use Disorder Partial Hospitalization Treatment Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by the plan.

**Participating Provider** – means any licensed Physician or Professional Healthcare Provider which has a contract or agreement with Blue Cross and Blue Shield to provide professional and ancillary services to persons enrolled under this benefit program.

**Participating Medical Group** – means any duly organized group of Physicians which has a contract or agreement with Blue Cross and Blue Shield to provide professional and ancillary services to persons enrolled under this benefit program.

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

**Permitted Cost Sharing Payments** – means Blue Cross and Blue Shield of Illinois follows the premium payment process established by the Affordable Care Act in accordance with all Federal requirements. Blue Cross and Blue Shield of Illinois does not accept cost-sharing payments from any other third party, which are referred to in this Policy as "Prohibited Third Party Cost Sharing Payments." Blue Cross and Blue Shield of Illinois only accepts cost-sharing payments from:

- A. The Member;
- B. The Member's family;
- C. Blue Cross and Blue Shield of Illinois accepts premium payments from the following third-party entities on behalf of Enrollees:
  - i. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
  - ii. An Indian tribe, tribal organization or urban Indian organization; and
  - iii. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.
- D. Blue Cross and Blue Shield of Illinois may accept premium payments on behalf of Enrollees from private, not-for-profit foundations, if the payments are:
  - i. For the entire coverage period of the Enrollee's Policy;
  - ii. Based solely on the financial status of the Enrollees;
  - iii. Regardless of the coverage the Enrollee chooses; and

- iv. Regardless of the Enrollee's health status.
  - E. Blue Cross and Blue Shield of Illinois may accept premium payments on behalf of Enrollees from a Trust, Power of Attorney or Legal Guardian;
  - F. Blue Cross and Blue Shield of Illinois will not construe payments from an employer as impermissible third-party payments, provided such payments do not create an Employee Retirement Income Security Act (ERISA) group health plan and either; or
    - i. The employer facilitates premium payment collection through payroll deduction or a similar method for the employee, and the employer is not paying any part of the premium either directly or through reimbursement; or
    - ii. The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer in place of group health insurance.
  - G. Blue Cross and Blue Shield of Illinois will accept payments on behalf of an Enrollee directly from an employer engaged in an ICHRA or QSEHRA, or a third-party payment coordination service, when such payments are made using allowable payment methods.
- Unauthorized premium and cost-sharing payments paid by a third party will not be credited to the Member's account and will be refunded to the unauthorized payer. If Blue Cross and Blue Shield of Illinois fails to receive payment in full from an authorized source by the end of any premium grace period, Blue Cross and Blue Shield of Illinois will retroactively terminate or cancel this coverage.
- Permitted Premium Payments** – means Blue Cross and Blue Shield of Illinois follows the premium payment process established by the Affordable Care Act in accordance with all Federal requirements. Blue Cross and Blue Shield of Illinois does not accept premium payments from any other third party, which are referred to in this Policy as "Prohibited Third Party Premium Payments." Blue Cross and Blue Shield of Illinois only accepts premium payments from:
- A. The Member;
  - B. The Member's family;
  - C. Blue Cross and Blue Shield of Illinois accepts premium payments from the following third-party entities on behalf of Enrollees:
    - i. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
    - ii. An Indian tribe, tribal organization or urban Indian organization; and
    - iii. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.
  - D. Blue Cross and Blue Shield of Illinois may accept premium payments on behalf of Enrollees from private, not-for-profit foundations, if the payments are:
    - i. For the entire coverage period of the Enrollee's Policy;
    - ii. Based solely on the financial status of the Enrollees;
    - iii. Regardless of the coverage the Enrollee chooses; and
    - iv. Regardless of the Enrollee's health status.
  - E. Blue Cross and Blue Shield of Illinois may accept premium payments on behalf of Enrollees from a Trust, Power of Attorney or Legal Guardian;

F. Blue Cross and Blue Shield of Illinois will not construe payments from an employer as impermissible third-party payments, provided such payments do not create an Employee Retirement Income Security Act (ERISA) group health plan and either; or

i. The employer facilitates premium payment collection through payroll deduction or a similar method for the employee, and the employer is not paying any part of the premium either directly or through reimbursement; or

ii. The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer in place of group health insurance.

G. Blue Cross and Blue Shield of Illinois will accept payments on behalf of an Enrollee directly from an employer engaged in an ICHRA or QSEHRA, or a third-party payment coordination service, when such payments are made using allowable payment methods.

Unauthorized premium and cost-sharing payments paid by a third party will not be credited to the Member's account and will be refunded to the unauthorized payer. If Blue Cross and Blue Shield of Illinois fails to receive payment in full from an authorized source by the end of any premium grace period, Blue Cross and Blue Shield of Illinois will retroactively terminate or cancel this coverage.

**Pharmacy** – means a state and federally licensed establishment where the practice of Pharmacy occurs, that is physically separate and apart from a 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 Therapy** – means the treatment by physical means by or under the supervision of a qualified physical therapist.

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

**Physician Assistant** – means a duly licensed Physician assistant performing under the direct supervision of a Physician.

**Podiatrist** – means a duly licensed podiatrist.

**Policy** – means the agreement between Blue Cross and Blue Shield and you, including this booklet, the Schedule Page, any addenda or riders that apply, the Exchange application and the individual applications, if any, of the persons covered under this Policy.

**Premium Tax Credit** – means a refundable premium tax credit an eligible individual may receive for taxable years ending after December 31, to the extent provided for under applicable law, where the credit is meant to offset all or a portion of the premium paid by the individual for coverage obtained through the Exchange during the preceding calendar year.

**Prescription Drug Provider** – means any Pharmacy which regularly dispenses drugs.

**Participating Prescription Drug Provider or Participating Pharmacy** – means a Preferred or Non-Preferred Pharmacy, including, but not limited to, an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy that has a written agreement with the Plan, or with the entity chosen by the Plan to administer its prescription drug program, to provide Covered Services at the time rendered.

**Primary Care Physician (PCP)** – A Physician, including general practitioners, family practitioners, internists, naturopaths, physician assistants, nurse practitioners who are in a Family Practice, pediatricians, obstetricians, and gynecologists who are MyBlue Plus POS Participating Professional Providers; Selected by or for a Member to be the Primary Care Provider; and responsible for providing initial and primary care to a Member, providing, supervising, and coordinating the continuity of a Member's care including specialty care.

**PRIOR AUTHORIZATION, EMERGENCY MENTAL ILLNESS or SUBSTANCE USE DISORDER ADMISSION REVIEW** - means a requirement that you must obtain authorization from Blue Cross and Blue Shield before you receive certain types of Covered Services designated by Blue Cross and Blue Shield.

**Private Duty Nursing Service** – means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing Service does not include Custodial Care Service.

**Prohibited Third Party Cost Sharing Payments** – See definition of Permitted Cost Sharing Payments.

**Prohibited Third Party Premium Payments** – See definition of Permitted Premium Payments.

**Provider** – means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) duly licensed to render Covered Services to you.

**Provider's Charge** – means a) in the case your Primary Care Physician, the amount that such Physician would have charged for a good or service had you not been enrolled under this benefit program.

**Psychologist** – means:

1. A Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologist Registration Act" (111 Ill. Rev. Stat. § 5301 et seq., as amended or substituted); or
  - a. In a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice; or
  - b. If practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Substance Use Disorder and who meets the following qualifications:
2. 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 postdoctoral and one year in an organized health services program; or
3. Is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College and has not less than six years' experience as a psychologist with at least two years of supervised experience in health services.

**Qualified Health Plan or QHP** – means a health care benefit program that has in effect a certification that it meets the applicable government standards, issued or recognized by each Exchange through which such program is offered.

**Qualified Health Plan Issuer or QHP Issuer** – means a health insurance issuer that offers a QHP in accordance with a certification from the Exchange.

**Qualified Individual** –means an individual who has been determined eligible to enroll in this Policy.

**Radiation Therapy** – means the use of ionizing radiation in the treatment of a medical illness or condition.

**Recommended Clinical Review** – means an optional voluntary review of a Provider's recommended medical procedure, treatment, or test, that does not require Prior Authorization, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and Medical Necessity requirements.

**Rescission** – has the meaning set forth in the "Rescission of Coverage" provision of this Policy.

**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.

**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, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders. Blue Cross and Blue Shield 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 Blue Cross

and Blue Shield as set forth in its current credentialing Policy, and otherwise meets all other credentialing requirements set forth in such Policy.

**Respite Care Services** – means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services for you.

**Routine Patient Costs** – means the cost for all items and services consistent with the coverage provided under this Policy that is typically covered for an Enrollee who is not enrolled in a clinical trial.

Routine Patient Costs do not include:

1. The Investigational item, device or service, itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

**Skilled Nursing Facility** – means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

**Skilled Nursing Service** – means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

**Specialist Physician** – means a Healthcare Provider or Physician who does not meet the definition of a Primary Care Care Provider, or Behavioral Health Practitioner.

**Speech Therapy** – means treatment for the correction of a speech impairment, including pervasive developmental disorders.

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

**Substance Use Disorder Treatment** – means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court-ordered evaluations, programs which are primarily for diagnostic evaluations, mental 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 Substance Use Disorder and which 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-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.

**Telehealth Services** – means a health service delivered by a health professional licensed, certified, or otherwise entitled to practice in Illinois and acting within the scope of the health professional's license, certification, or entitlement to a patient in a different physical location than the health professional using telecommunications or information technology.

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

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

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

**Tobacco Use Cessation Program** – means a program recommended by a Physician that follows evidence-based treatment, such as outlined in the United States Public Health Service guidelines to tobacco use cessation. "Tobacco Use Cessation Program" includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products. "Tobacco Use Cessation Program" includes education and counseling by Physicians or associated medical personnel and all FDA-approved medications for the treatment of tobacco dependence irrespective of whether they are available only over the counter, only by prescription, or both over the counter and by prescription. In addition, Blue Cross and Blue Shield will communicate with you on an annual basis the importance and value of early detection and proactive management of cardiovascular disease.

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

**Totally Disabled** – means, with respect to an eligible person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the eligible person is or becomes qualified by reason of experience, education or training or with respect to an Enrollee other than an eligible person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a similarly situated person who is in good health.

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

**Urgent/Expedited Clinical Appeal** – means an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatments ordered by a health care Provider that, if a decision is denied, may significantly increase the risk to your health.

**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 (a) interactive audio communication (via telephone or other similar technology), or (b) interactive audio/video examination and communication (via online portal, mobile application or similar technology) to you at the time services are rendered, operating within the scope of such license.

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

**Vitamin D Testing** – means vitamin D blood testing that measures the level of vitamin D in a person's blood.

## **AMERICAN INDIAN/ALASKAN NATIVE COSTSHARING NOTICE**

This Notice is hereby adopted and incorporated into your Policy. Please read it carefully.

If you are an American Indian/Alaskan Native enrolled under this Policy, the following variations in cost-sharing amounts will apply to your coverage under This Qualified Health Plan (QHP) offered on the Exchange:

If you have a household income of less than 300% of the Federal Poverty Level, you may be eligible for a Zero Cost Sharing (ZCS) Plan.

If you are enrolled in a ZCS QHP without an out-of-network benefit (e.g. HMO or EPO), you will have your cost-sharing for medical and drug essential health benefits, as defined in your Policy, reduced to zero for in-network services only. Your ZCS QHP does not provide benefits for services received from an out-of-network Provider, so you may be responsible for all costs associated for services obtained from such a Provider. Any preauthorization requirements, balance billing/overage from out-of-network Providers, and any maximum benefit limitations or exclusions will still apply.

If you are not eligible for a ZCS Plan, you may be eligible for a Limited Cost Sharing (LSC) Plan.

Under the LCS plans, you will have cost-sharing for medical and drug Essential Health Benefits, as defined in this Policy, reduced to zero when you receive services from an Indian Health Service Provider, other tribal or urban Indian Organization Provider ("I/T/U Providers"), or through a referral issued by an I/T/U Provider under the Contract Health Service ("CHS") program. If you do not receive services from an I/T/U Provider or through a CHS referral, you may be responsible for cost-sharing described in your benefit materials. Any applicable preauthorization requirements, balance billing/overage from out-of-network Providers, any maximum benefit limitations or exclusions, will still apply.

For information on whether a specific Provider is an in-network Provider or out-of-network Provider or whether a specific Provider is an IHS or other tribal or urban Indian Organization Provider, call a customer service representative at the number located on the back of your identification card

**NOTICE OF  
PROTECTION PROVIDED BY  
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
  - \$300,000 for death benefits
  - \$100,000 for cash surrender or withdrawal values
- Health Insurance
  - \$500,000 for health benefit plans\*
  - \$300,000 for disability insurance benefits
  - \$300,000 for long-term care insurance benefits
  - \$100,000 for other types of health insurance benefits
- Annuities
  - \$250,000 for withdrawal and cash values

\* The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is \$500,000.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.ilhiga.org](http://www.ilhiga.org) or contact:

Illinois Life and Health Insurance Guaranty Association  
901 Warrenville Road, Suite 400  
Lisle, Illinois 60532-4324

Illinois Department of Insurance  
4th Floor  
320 West Washington Street  
Springfield, Illinois 62767

**Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When**

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**selecting an insurance company or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.**

**The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.**

(Source: Amended at 43 Ill. Reg. 3290, effective February 25, 2019)

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BlueCross BlueShield of Illinois

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

**Health care coverage is important for everyone.**

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St., 35<sup>th</sup> Floor  
Chicago, IL 60601

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

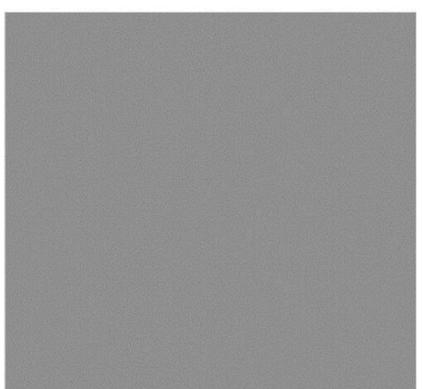
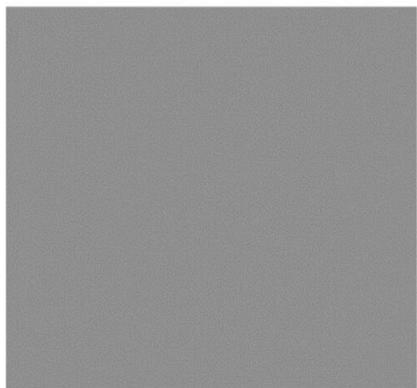
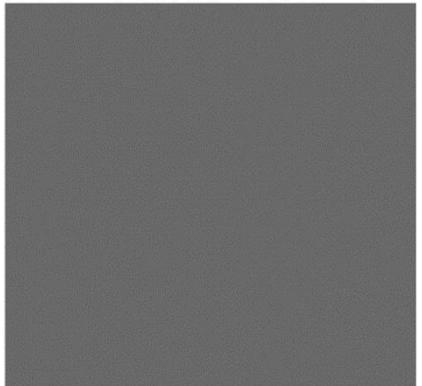
You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services 200 Independence Avenue SW Room 509F, HHH Building 1019 Washington, DC 20201	Phone: 800-368-1019 TTY/TDD: 800-537-7697 Complaint Portal: <a href="https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf">https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf</a> Complaint Forms: <a href="https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html">https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html</a>
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**To receive language or communication assistance free of charge, please call us at 855-710-6984.**

Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	.للتلقى المساعدة اللغوية أو التواصـل مجاناً، يرجى الاتصال بـنا على الرقم 855-710-6984
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમારો 855-710-6984 પર કોલ કરો.
हिन्दी	नि:शुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiama il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinit'sá'góó, shá ata' hodooni nínízingo, t'áajíík'eh bee náhaz'á. 1-866-560-4042 ji' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لئے، براہ کرم بین 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.

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