BlueCross BlueShield of Illinois

LSC GROUP BENEFITS PLAN

MEDICAL BENEFIT BOOKLET

Effective Date: January 1, 2024

Please Note: The terms Preferred and Non-Preferred Provider are used throughout this document to describe a Medical Services Provider's participation in the PPO Network. Also referred to as In-Network and Out-of-Network, the terms Preferred/Non-Preferred and In-Network/Out-of-Network are interchangeable.

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This Medical Benefit Booklet is a summary of the covered services available to you under the medical benefit, which is a component part of the LSC Group Benefits Plan (the "Plan") sponsored by LSC Communications LLC ("Plan Sponsor"). This Medical Benefit Booklet, together with the LSC Group Benefits Plan and the LSC Flexible Benefits Plan Summary Plan Description (the "SPD") and other Plan summaries, serves as the official summary plan description for the Plan. You are encouraged to read all portions together and in their entirety.

BlueCross BlueShield of Illinois

MEDICAL SCHEDULE OF BENEFITS

Benefit Period: January 1, 2024 – December 31, 2024

MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductible per benefit period		
Individual	$1,500	$2,500
Family (non-embedded)	$3,000	$5,000
Deductible does not share between preferred and nonpreferred		
Generally, each ***covered person*** must pay all of the costs from providers up to the deductible amount before the ***Plan*** begins to pay. **Non-embedded family deductible**: Any number of covered family members may help to satisfy the family deductible before this ***Plan*** begins to pay for ***covered expenses*** that are subject to the deductible.		
Out-of-Pocket Expense Limit per benefit period (includes deductible, ***coinsurance***, ***copays***, and prescription drug cost-share)		
Individual	$5,000	$10,000
Family (embedded)	$10,000	$19,600
Out-of-pocket expense limit does not share between preferred and nonpreferred		
The out-of-pocket expense limit is the most the ***covered person*** could pay in a year for ***covered expenses***. The ***Plan*** will pay the designated percentage of ***covered expenses*** until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise. **Embedded family out-of-pocket expense limit:** Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual out-of-pocket expense limit. The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%: • expenses not covered by the ***Plan*** • expenses in excess of amounts covered by the ***Plan*** • expenses in excess of ***customary and reasonable amount***		
Standard *coinsurance* paid by the *Plan*	80%	60%

MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Acupuncture	80% after deductible	60% after deductible
	Maximum: 20 visits per benefit period	
Allergy Services Allergy testing, injections and serum Specialist	$40 ***copay*** deductible waived	60% after deductible
Ambulance (Land/Air)	80% after deductible	***preferred provider*** benefit applies
Applied Behavior Analysis Therapy (ABA)	80% after deductible	60% after deductible
Birthing Center	80% after deductible	60% after deductible
Blood *(Blood storage and transfusions)*	80% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	60% after deductible
Chemotherapy	$40 ***copay*** deductible waived	60% after deductible
Chiropractic Care Office visits, spinal manipulation, adjustments and x-rays	$40 ***copay*** deductible waived	60% after deductible
	Maximum: 20 visits per benefit period	
Contraceptives	See Women's Preventive Services	
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*	80% after deductible	60% after deductible
Diagnostic Services – Minor Laboratory services (includes independent labs)	80% after deductible	60% after deductible
X-ray services (includes freestanding facilities)	80% after deductible	60% after deductible
Dialysis Therapy or Treatment	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Emergency Room Services ***Emergency Medical Condition* Care** ***Facility*** (***copay*** waived if admitted)	$500 ***copay*** deductible waived	***preferred provider*** benefit applies
Physician	80% deductible waived	***preferred provider*** benefit applies

MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Emergency Room Services (Cont'd)		
Non-***Emergency Medical Condition*** **Care**		
Facility (***copay*** waived if admitted)	$500 ***copay*** deductible waived	$500 ***copay*** deductible waived
Physician	80% deductible waived	60% deductible waived
	Non-Emergency use of the ER, without a later admission for reasons that do not meet the definition of emergency under the Affordable Care Act will be assessed a $500 penalty and the penalty should not apply towards the deductible or out-of-pocket maximums.	
Extended Care Facility	80% after deductible	60% after deductible
	Maximum: 90 days per benefit period	
Hearing Aids		
Prescription hearing aids and related services	80% after deductible	60% after deductible
	Maximum: One hearing aid per 3 calendar years up to maximum of $5,000.	
Home Health Care		
Home health care visits	80% after deductible	60% after deductible
	Maximum: 120 visits per benefit period combined with private duty nursing	
Home health care supplies & services	80% after deductible	60% after deductible
IV therapy	80% after deductible	60% after deductible
Hospice Care		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Hospital – Inpatient		
Facility	80% after deductible	60% after deductible
Physician/Surgeon	80% after deductible	60% after deductible
Hospital – Outpatient & Ambulatory Surgical Facility		
Facility	80% after deductible	60% after deductible
Physician/Surgeon	80% after deductible	60% after deductible

MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Infertility Services		
Diagnostic testing to determine infertility	Based on service provided	Based on service provided
Medications and treatments	Not Covered	Not Covered
Infusion Therapy	80% after deductible	60% after deductible
MDLive **Telemedicine**		
Medical	$25 ***copay*** deductible waived	Not Covered
Behavioral Health	$25 ***copay*** deductible waived	Not Covered
Occupational Therapy	80% after deductible	60% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	
Office Visit & Other Services (one ***copay*** per provider per date of service)		
Office visit		
Primary care physician (includes outpatient visits for ***mental health disorders/substance use disorder***)	$25 ***copay*** deductible waived	60% after deductible
Specialist	$40 ***copay*** deductible waived	60% after deductible
Surgery		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
Lab		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
X-ray		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
Other services		
Primary care physician	$25 ***copay*** deductible waived	60% after deductible
Specialist	$40 ***copay*** deductible waived	60% after deductible

MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Orthotics	80% after deductible	60% after deductible
Physical Therapy	80% after deductible	60% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	
Podiatry Services	Based on service provided	Based on service provided
Pregnancy		
Initial pre-natal visit and urinalysis	100% deductible waived	60% after deductible
Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the ***Affordable Care Act***)	100% deductible waived	60% after deductible
Post-natal care and other non-routine/non-preventive pregnancy related care.	Based on service provided	Based on service provided
Delivery	80% after deductible	60% after deductible
Private Duty Nursing		
Inpatient	Not Covered	Not Covered
Outpatient	80% after deductible	60% after deductible
	Maximum: 120 visits per benefit period combined with Home Health Care.	
Prostheses	80% after deductible	60% after deductible
Radiation Therapy	80% after deductible	60% after deductible
Respiratory Therapy	80% after deductible	60% after deductible
Retail Clinic Visits	$25 ***copay*** deductible waived	60% after deductible
Routine Preventive Care/Wellness Benefits Includes all evidence-based supplies 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). For additional information visit: http://www.uspreventiveservicestaskforce.org	100% deductible waived	60% after deductible
Routine Prostate Examinations	100% deductible waived	60% after deductible

MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Speech Therapy	80% after deductible	60% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	
Telemedicine Services		
Primary care physician (includes outpatient visits for ***mental health disorders/substance use disorder***)	$25 ***copay*** deductible waived	60% after deductible
Specialist	$40 ***copay*** deductible waived	60% after deductible
Temporomandibular Joint Syndrome (TMJ) Treatment *(includes intraoral orthotics, prosthetics and therapy)* Orthodontia services not covered	Based on service provided	Based on service provided
Transplants (Organ or Tissue)		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Transportation and lodging	80% after deductible	60% after deductible
	Maximum: Transportation $10,000 per transplant. Recipient must reside more than 50 miles from transplant facility.	
Urgent Care Center		
Visit	80% after deductible	60% after deductible
All other services	80% after deductible	60% after deductible
Vision – Routine Services *(Routine vision services required by the **Affordable Care Act** shall be covered under the Routine Preventive Care benefit)*	Not Covered	Not Covered
Weight Loss Services		
Office visit and basic diagnostic testing, including laboratory services and electrocardiograms (EKGs), but does not include advanced imaging services	Based on service provided	Based on service provided
Surgical treatment	Based on service provided	Based on service provided
Non-surgical treatment and programs	Not Covered	Not Covered
Wigs *(Required due to chemotherapy, radiation therapy, or alopecia)*	80% after deductible	60% after deductible
	Maximum: $1,000 maximum every 24 months.	

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MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Women's Preventive Services As required by the ***Affordable Care Act***	100% deductible waived	60% after deductible
All Other C*overed Expenses*	80% after deductible	60% after deductible

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PRESCRIPTION DRUG PROGRAM SCHEDULE OF BENEFITS

Benefit Period: January 1, 2024 – December 31, 2024

PRESCRIPTION DRUG PROGRAM BENEFITS – COPAY ADVANTAGE	PARTICIPATING PHARMACY	NONPARTICIPATING PHARMACY
Participating Pharmacy Out-of-Pocket Expense Limit (per benefit period) is the same as and is combined with the Medical Preferred Provider Out-of-Pocket Expense Limit.		
The ***Plan*** will pay the designated percentage of ***covered expenses*** and will apply the applicable ***copay*** until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise.		
Retail Pharmacy (30-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% deductible waived	Not Applicable
Generic	20% minimum $10 up to maximum of $40	
Formulary Brand Name	20% minimum $40 up to maximum of $75	
Non-Formulary Brand Name	20% minimum $50 up to maximum of $125	
Mail Order Pharmacy (90-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% deductible waived	Not Covered
Generic	20% minimum $25 up to maximum of $100	
Formulary Brand Name	20% minimum $100 up to maximum of $185	
Non-Formulary Brand Name	20% minimum $140 up to maximum of $315	
Specialty Drugs (30-day supply)	$150 ***copay***	Not Covered
If the ***covered person*** selects a brand drug when a generic equivalent is available, the ***covered person*** is responsible for the brand ***copay*** plus the cost difference between the generic and brand equivalent. Maintenance medication under 90-day My Way: 90-day supply at Retail or Mail Order. For ***nonparticipating pharmacy*** the ***covered person*** is responsible for 25% of the eligible amount after ***coinsurance***.		

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MEDICAL SCHEDULE OF BENEFITS

Benefit Period: January 1, 2024 – December 31, 2024

MEDICAL BENEFITS-HSA CORE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductible per benefit period (medical and prescription drug deductibles)		
Individual	$7,000	$14,000
Family (embedded)	$14,000	$28,000
Deductible does not share between preferred and nonpreferred		
Generally, each ***covered person*** must pay all of the costs from providers up to the deductible amount before the ***Plan*** begins to pay. **Embedded family deductible**: Any number of covered family members may help to satisfy the family deductible, but no family member will incur more than the individual deductible amount.		
Out-of-Pocket Expense Limit per benefit period (includes deductible, ***coinsurance***, and prescription drug cost-share)		
Individual	$7,000	$14,000
Family (embedded)	$14,000	$28,000
Out-of-pocket expense limit does not share between preferred and nonpreferred		
The out-of-pocket expense limit is the most the ***covered person*** could pay in a year for ***covered expenses***. The ***Plan*** will pay the designated percentage of ***covered expenses*** until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise. **Embedded family out-of-pocket expense limit:** Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual out-of-pocket expense limit. The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%: • expenses not covered by the ***Plan*** • expenses in excess of amounts covered by the ***Plan*** • expenses in excess of ***customary and reasonable amount***		
Standard *coinsurance* paid by the *Plan*	100%	100%

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MEDICAL BENEFITS-HSA CORE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Acupuncture	100% after deductible	100% after deductible
	Maximum: 20 visits per benefit period	
Allergy Services		
Allergy testing, injections and serum		
Specialist	100% after deductible	100% after deductible
Ambulance (Land/Air)	100% after deductible	***preferred provider*** benefit applies
Applied Behavior Analysis Therapy (ABA)	100% after deductible	100% after deductible
Birthing Center	100% after deductible	100% after deductible
Blood *(Blood storage and transfusions)*	100% after deductible	100% after deductible
Cardiac Rehabilitation	100% after deductible	100% after deductible
Chemotherapy	100% after deductible	100% after deductible
Chiropractic Care Office visits, spinal manipulation, adjustments and x-rays	100% after deductible	100% after deductible
	Maximum: 20 visits per benefit period	
Contraceptives	See Women's Preventive Services	
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*	100% after deductible	100% after deductible
Diagnostic Services – Minor		
Laboratory services (includes independent labs)	100% after deductible	100% after deductible
X-ray services (includes freestanding facilities)	100% after deductible	100% after deductible
Dialysis Therapy or Treatment	100% after deductible	100% after deductible
Durable Medical Equipment	100% after deductible	100% after deductible

MEDICAL BENEFITS-HSA CORE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Emergency Room Services		
***Emergency Medical Condition* Care**		
Facility	100% after deductible	***preferred provider*** benefit applies
Physician	100% after deductible	***preferred provider*** benefit applies
Non-***Emergency Medical Condition* Care**		
Facility	100% after deductible	***preferred provider*** benefit applies
Physician	100% after deductible	***preferred provider*** benefit applies
	Non-Emergency use of the ER, without a later admission for reasons that do not meet the definition of emergency under the Affordable Care Act will be assessed a $500 penalty and the penalty should not apply towards the deductible or out-of-pocket maximums.	
Extended Care Facility	100% after deductible	100% after deductible
	Maximum: 90 days per benefit period	
Hearing Aids		
Prescription hearing aids and related services	100% after deductible	100% after deductible
	Maximum: One hearing aid per 3 calendar years up to maximum of $5,000.	
Home Health Care		
Home health care visits	100% after deductible	100% after deductible
	Maximum: 120 visits per benefit period combined with private duty nursing	
Home health care supplies & services	100% after deductible	100% after deductible
IV therapy	100% after deductible	100% after deductible
Hospice Care		
Inpatient	100% after deductible	100% after deductible
Outpatient	100% after deductible	100% after deductible
Hospital – Inpatient		
Facility	100% after deductible	100% after deductible
Physician/Surgeon	100% after deductible	100% after deductible
Hospital – Outpatient & Ambulatory Surgical Facility		
Facility	100% after deductible	100% after deductible
Physician/Surgeon	100% after deductible	100% after deductible

MEDICAL BENEFITS-HSA CORE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Infertility Services		
Diagnostic testing to determine infertility	Based on service provided	Based on service provided
Medications and treatments	Not Covered	Not Covered
Infusion Therapy	100% after deductible	100% after deductible
MDLive **Telemedicine**		
Medical	$10 ***copay*** deductible waived	Not covered
Behavioral Health	$10 ***copay*** deductible waived	Not covered
Occupational Therapy	100% after deductible	100% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	
Office Visit & Other Services		
Office visit		
Primary care physician (includes outpatient visits for ***mental health disorders/ substance use disorder***)	100% after deductible	100% after deductible
Specialist	100% after deductible	100% after deductible
Surgery	100% after deductible	100% after deductible
Lab	100% after deductible	100% after deductible
X-ray	100% after deductible	100% after deductible
Other services	100% after deductible	100% after deductible
Orthotics	100% after deductible	100% after deductible
Physical Therapy	100% after deductible	100% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	
Podiatry Services	Based on service provided	Based on service provided

MEDICAL BENEFITS-HSA CORE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Pregnancy		
Initial pre-natal visit and urinalysis	100% deductible waived	100% after deductible
Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the ***Affordable Care Act***)	100% deductible waived	100% after deductible
Post-natal care and other non-routine/non-preventive pregnancy related care.	Based on service provided	Based on service provided
Delivery	100% after deductible	100% after deductible
Private Duty Nursing		
Inpatient	Not Covered	Not Covered
Outpatient	100% after deductible	100% after deductible
	Maximum: 120 visits per benefit period combined with Home Health Care.	
Prostheses	100% after deductible	100% after deductible
Radiation Therapy	100% after deductible	100% after deductible
Respiratory Therapy	100% after deductible	100% after deductible
Retail Clinic Visits	100% after deductible	100% after deductible
Routine Preventive Care/Wellness Benefits Includes all evidence-based supplies 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). For additional information visit: http://www.uspreventiveservicestaskforce.org	100% deductible waived	100% after deductible
Routine Prostate Examinations	100% deductible waived	100% after deductible
Speech Therapy	100% after deductible	100% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	

MEDICAL BENEFITS-HSA CORE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Telemedicine Services		
Primary care physician (includes outpatient visits for ***mental health disorders/substance use disorder***)	100% after deductible	100% after deductible
Specialist	100% after deductible	100% after deductible
Temporomandibular Joint Syndrome (TMJ) Treatment *(includes intraoral orthotics, prosthetics and therapy)* Orthodontia services not covered	Based on service provided	Based on service provided
Transplants (Organ or Tissue)		
Facility	100% after deductible	100% after deductible
Physician	100% after deductible	100% after deductible
Transportation and lodging	100% after deductible	100% after deductible
	Maximum: Transportation $10,000 per transplant. Recipient must reside more than 50 miles from transplant facility.	
Urgent Care Center		
Visit	100% after deductible	100% after deductible
All other services	100% after deductible	100% after deductible
Vision – Routine Services *(Routine vision services required by the **Affordable Care Act** shall be covered under the Routine Preventive Care benefit)*	Not Covered	Not Covered
Weight Loss Services		
Office visit and basic diagnostic testing, including laboratory services and electrocardiograms (EKGs), but does not include advanced imaging services	Based on service provided	Based on service provided
Surgical treatment	Based on service provided	Based on service provided
Non-surgical treatment and programs	Not Covered	Not Covered
Wigs *(Required due to chemotherapy, radiation therapy, or alopecia)*	100% after deductible	100% after deductible
	Maximum: $1,000 maximum every 24 months.	
Women's Preventive Services As required by the ***Affordable Care Act***	100% deductible waived	100% after deductible
All Other *Covered Expenses*	100% after deductible	100% after deductible

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PRESCRIPTION DRUG PROGRAM SCHEDULE OF BENEFITS

Benefit Period: January 1, 2024 – December 31, 2024

PRESCRIPTION DRUG PROGRAM BENEFITS – HSA CORE	PARTICIPATING PHARMACY	NONPARTICIPATING PHARMACY
Deductible per benefit period **is combined with the Medical Preferred Provider deductible.**		
Participating Pharmacy Out-of-Pocket Expense Limit (per benefit period) is the same as and is combined with the Medical Preferred Provider Out-of-Pocket Expense Limit.		
The ***Plan*** will pay the designated percentage of ***covered expenses*** and will apply the applicable ***coinsurance*** after deductible until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise.		
Retail Pharmacy (30-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% deductible waived	Not Applicable
Generic	100% after deductible	100% after deductible
Formulary Brand Name	100% after deductible	100% after deductible
Non-Formulary Brand Name	100% after deductible	100% after deductible
Mail Order Pharmacy (90-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% deductible waived	Not Covered
Generic	100% after deductible	100% after deductible
Formulary Brand Name	100% after deductible	100% after deductible
Non-Formulary Brand Name	100% after deductible	100% after deductible
Specialty Drugs (30-day supply)	100% after deductible	Not Covered
If the ***covered person*** selects a brand drug when a generic equivalent is available, the ***covered person*** is responsible for the brand ***copay*** plus the cost difference between the generic and brand equivalent. Maintenance medication under 90-day My Way: 90-day supply at Retail or Mail Order. For ***nonparticipating pharmacy*** the ***covered person*** is responsible for 25% of the eligible amount after ***coinsurance***.		

BlueCross BlueShield of Illinois

MEDICAL SCHEDULE OF BENEFITS

Benefit Period: January 1, 2024 – December 31, 2024

MEDICAL BENEFITS-HSA VALUE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductible per benefit period (medical and prescription drug deductibles)		
Individual	$2,500	$5,000
Family (non-embedded)	$5,000	$10,000
Deductible does not share between preferred and nonpreferred		
Generally, each ***covered person*** must pay all of the costs from providers up to the deductible amount before the ***Plan*** begins to pay. **Non-embedded family deductible**: Any number of covered family members may help to satisfy the family deductible before this ***Plan*** begins to pay for ***covered expenses*** that are subject to the deductible.		
Out-of-Pocket Expense Limit per benefit period (includes deductible, ***coinsurance***, and prescription drug cost-share)		
Individual	$5,000	$10,000
Family (embedded)	$10,000	$19,600
Out-of-pocket expense limit does not share between preferred and nonpreferred		
The out-of-pocket expense limit is the most the ***covered person*** could pay in a year for ***covered expenses***. The ***Plan*** will pay the designated percentage of ***covered expenses*** until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise. **Embedded family out-of-pocket expense limit:** Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual out-of-pocket expense limit. The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%: • expenses not covered by the ***Plan*** • expenses in excess of amounts covered by the ***Plan*** • expenses in excess of ***customary and reasonable amount***		
Standard *coinsurance* paid by the *Plan*	80%	50%

MEDICAL BENEFITS-HSA VALUE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Acupuncture	80% after deductible	50% after deductible
	Maximum: 20 visits per benefit period	
Allergy Services		
Allergy testing, injections and serum		
Specialist	80% after deductible	50% after deductible
Ambulance (Land/Air)	80% after deductible	***preferred provider*** benefit applies
Applied Behavior Analysis Therapy (ABA)	80% after deductible	50% after deductible
Birthing Center	80% after deductible	50% after deductible
Blood *(Blood storage and transfusions)*	80% after deductible	50% after deductible
Cardiac Rehabilitation	80% after deductible	50% after deductible
Chemotherapy	80% after deductible	50% after deductible
Chiropractic Care Office visits, spinal manipulation, adjustments and x-rays	80% after deductible	50% after deductible
	Maximum: 20 visits per benefit period	
Contraceptives	See Women's Preventive Services	
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*	80% after deductible	50% after deductible
Diagnostic Services – Minor		
Laboratory services (includes independent labs)	80% after deductible	50% after deductible
X-ray services (includes freestanding facilities)	80% after deductible	50% after deductible
Dialysis Therapy or Treatment	80% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	50% after deductible

MEDICAL BENEFITS-HSA VALUE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Emergency Room Services		
***Emergency Medical Condition* Care**		
Facility	80% after deductible	***preferred provider*** benefit applies
Physician	80% after deductible	***preferred provider*** benefit applies
Non-***Emergency Medical Condition* Care**		
Facility	80% after deductible	50% after deductible
Physician	80% after deductible	50% after deductible
	Non-Emergency use of the ER, without a later admission for reasons that do not meet the definition of emergency under the Affordable Care Act will be assessed a $500 penalty and the penalty should not apply towards the deductible or out-of-pocket maximums.	
Extended Care Facility	80% after deductible	50% after deductible
	Maximum: 90 days per benefit period	
Hearing Aids		
Prescription hearing aids and related services	80% after deductible	50% after deductible
	Maximum: One hearing aid per 3 calendar years up to maximum of $5,000.	
Home Health Care		
Home health care visits	80% after deductible	50% after deductible
	Maximum: 120 visits per benefit period combined with private duty nursing	
Home health care supplies & services	80% after deductible	50% after deductible
IV therapy	80% after deductible	50% after deductible
Hospice Care		
Inpatient	80% after deductible	50% after deductible
Outpatient	80% after deductible	50% after deductible
Hospital – Inpatient		
Facility	80% after deductible	50% after deductible
Physician/Surgeon	80% after deductible	50% after deductible
Hospital – Outpatient & Ambulatory Surgical Facility		
Facility	80% after deductible	50% after deductible
Physician/Surgeon	80% after deductible	50% after deductible

MEDICAL BENEFITS-HSA VALUE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Infertility Services		
Diagnostic testing to determine infertility	Based on service provided	Based on service provided
Medications and treatments	Not Covered	Not Covered
Infusion Therapy	80% after deductible	50% after deductible
MDLive **Telemedicine**		
Medical	$10 ***copay*** deductible waived	Not covered
Behavioral Health	$10 ***copay*** deductible waived	Not covered
Occupational Therapy	80% after deductible	50% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	
Office Visit & Other Services		
Office visit		
Primary care physician (includes outpatient visits for ***mental health disorders/substance use disorder***)	80% after deductible	50% after deductible
Specialist	80% after deductible	50% after deductible
Surgery	80% after deductible	50% after deductible
Lab	80% after deductible	50% after deductible
X-ray	80% after deductible	50% after deductible
Other services	80% after deductible	50% after deductible
Orthotics	80% after deductible	50% after deductible
Physical Therapy	80% after deductible	50% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	
Podiatry Services	Based on service provided	Based on service provided

MEDICAL BENEFITS-HSA VALUE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Pregnancy		
Initial pre-natal visit and urinalysis	100% deductible waived	50% after deductible
Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the ***Affordable Care Act***)	100% deductible waived	50% after deductible
Post-natal care and other non-routine/non-preventive pregnancy related care.	Based on service provided	Based on service provided
Delivery	80% after deductible	50% after deductible
Private Duty Nursing		
Inpatient	Not Covered	Not Covered
Outpatient	80% after deductible	50% after deductible
	Maximum: 120 visits per benefit period combined with Home Health Care.	
Prostheses	80% after deductible	50% after deductible
Radiation Therapy	80% after deductible	50% after deductible
Respiratory Therapy	80% after deductible	50% after deductible
Retail Clinic Visits	80% after deductible	50% after deductible
Routine Preventive Care/Wellness Benefits Includes all evidence-based supplies 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). For additional information visit: http://www.uspreventiveservicestaskforce.org	100% deductible waived	50% after deductible
Routine Prostate Examinations	100% deductible waived	50% after deductible
Second Surgical Opinion	80% after deductible	50% after deductible
Speech Therapy	80% after deductible	50% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	

MEDICAL BENEFITS-HSA VALUE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Telemedicine Services		
Primary care physician (includes outpatient visits for ***mental health disorders/substance use disorder***)	80% after deductible	50% after deductible
Specialist	80% after deductible	50% after deductible
Temporomandibular Joint Syndrome (TMJ) Treatment *(includes intraoral orthotics, prosthetics and therapy)* Orthodontia services not covered	Based on service provided	Based on service provided
Transplants (Organ or Tissue)		
Facility	80% after deductible	50% after deductible
Physician	80% after deductible	50% after deductible
Transportation and lodging	80% after deductible	50% after deductible
	Maximum: Transportation $10,000 per transplant. Recipient must reside more than 50 miles from transplant facility.	
Urgent Care Center		
Visit	80% after deductible	50% after deductible
All other services	80% after deductible	50% after deductible
Vision – Routine Services *(Routine vision services required by the **Affordable Care Act** shall be covered under the Routine Preventive Care benefit)*	Not Covered	Not Covered
Weight Loss Services		
Office visit and basic diagnostic testing, including laboratory services and electrocardiograms (EKGs), but does not include advanced imaging services	Based on service provided	Based on service provided
Surgical treatment	Based on service provided	Based on service provided
Non-surgical treatment and programs	Not Covered	Not Covered
Wigs *(Required due to chemotherapy, radiation therapy, or alopecia)*	80% after deductible	50% after deductible
	Maximum: $1,000 maximum every 24 months.	
Women's Preventive Services As required by the ***Affordable Care Act***	100% deductible waived	50% after deductible
All Other *Covered Expenses*	80% after deductible	50% after deductible

BlueCross BlueShield of Illinois

PRESCRIPTION DRUG PROGRAM SCHEDULE OF BENEFITS

Benefit Period: January 1, 2024 – December 31, 2024

PRESCRIPTION DRUG PROGRAM BENEFITS – HSA VALUE	PARTICIPATING PHARMACY	NONPARTICIPATING PHARMACY
Deductible per benefit period **is combined with the Medical Preferred Provider deductible.**		
Participating Pharmacy Out-of-Pocket Expense Limit (per benefit period) is the same as and is combined with the Medical Preferred Provider Out-of-Pocket Expense Limit.		
The ***Plan*** will pay the designated percentage of ***covered expenses*** and will apply the applicable ***coinsurance*** after deductible until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise.		
Retail Pharmacy (30-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% deductible waived	Not Applicable
Generic	20% after deductible	20% after deductible
Formulary Brand Name	20% after deductible	20% after deductible
Non-Formulary Brand Name	20% after deductible	20% after deductible
Mail Order Pharmacy (90-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% deductible waived	Not Covered
Generic	20% after deductible	Not Covered
Formulary Brand Name	20% after deductible	Not Covered
Non-Formulary Brand Name	20% after deductible	Not Covered
Specialty Drugs (30-day supply)	20% after deductible	Not Covered
If the ***covered person*** selects a brand drug when a generic equivalent is available, the ***covered person*** is responsible for the brand ***copay*** plus the cost difference between the generic and brand equivalent. Maintenance medication under 90-day My Way: 90-day supply at Retail or Mail Order. For ***nonparticipating pharmacy*** the ***covered person*** is responsible for 25% of the eligible amount after ***coinsurance***.		

BlueCross BlueShield of Illinois

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a ***preferred provider*** or a ***nonpreferred provider***.

PREFERRED PROVIDER

A ***preferred provider*** is a ***physician***, ***hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a ***negotiated rate*** for services rendered to ***covered persons***. In turn, the PPO has an agreement with the ***plan administrator*** or ***claims processor*** to allow access to ***negotiated rates*** for services rendered to ***covered persons***. The PPO's name and/or logo is shown on the front of the ***covered person's*** ID card. The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate*** for ***covered expenses***. ***Covered persons*** should contact the ***employer's*** Human Resources Department, contact the ***claims processor***, or review the PPO's website for a current listing of ***preferred providers***.

NONPREFERRED PROVIDER

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization***. Except as explained below, the ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense***. The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***nonpreferred provider covered expenses***. The ***covered person*** may be responsible for the remaining balance, which may result in greater out-of-pocket expenses to the ***covered person*** except as explained below.

1. If a ***nonpreferred provider*** has not satisfied the Notice and Consent Criteria described under number 6. below, for certain items and services, ***covered expenses*** for such services rendered at a ***preferred provider facility*** will be:

    a. Paid in accordance with the ***preferred provider cost sharing***;
    b. Subject to the ***preferred provider*** out-of-pocket expense limit; and
    c. Paid based on the lesser of the ***qualifying payment amount*** or the ***nonpreferred provider's*** actual charge; or when applicable:

        i. In a State that has in effect an applicable specified State law, the amount determined in accordance with such law; or
        ii. In a State that has an all-payer model agreement that applies to this ***Plan***, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

    The ***covered person's cost sharing*** will be calculated based on the ***recognized amount*** and ***nonpreferred providers*** may not balance bill for amounts in excess of the ***covered person's cost sharing***. If the ***out-of-network rate*** exceeds the ***recognized amount***, the difference will not be subject to the deductible.

    The following types of services provided in a ***preferred provider facility*** by a ***nonpreferred provider*** will be covered as explained in this section, regardless of whether the ***nonpreferred provider*** satisfies the Notice and Consent Criteria described in section 6. below:

    d. Ancillary services, including:

        i. Items and services related to emergency medicine, anesthesiology, pathology, radiology, neonatology (whether provided by a ***physician*** or non-***physician*** practitioner);
        ii. Items and services provided by assistant surgeons, hospitalists, and intensivists;
        iii. Diagnostic services including radiology and laboratory services; and

iv. Items and services provided by a ***nonpreferred provider*** if there is no ***preferred provider*** who can furnish such item or service at such ***facility***; and

e. Items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

2. ***Covered expenses*** for ***emergency services*** furnished by a ***nonpreferred provider*** will be:

a. Paid in accordance with the ***preferred provider cost sharing***;
b. Subject to the ***preferred provider*** out-of-pocket expense limit; and
c. Paid based on the lesser of the ***qualifying payment amount*** or the ***nonpreferred provider's*** actual charge:

i. In a State that has in effect an applicable specified State law, the amount determined in accordance with such law; or
ii. In a State that has an all-payer model agreement that applies to this ***Plan***, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

The ***covered person's cost sharing*** will be calculated based on the ***recognized amount*** and ***nonpreferred providers*** may not balance bill for amounts in excess of the ***covered person's cost sharing***. If the ***out-of-network rate*** exceeds the ***recognized amount***, the difference will not be subject to the deductible.

3. ***Covered expenses*** for air ambulance services furnished by a ***nonpreferred provider*** will be:

a. Paid in accordance with the ***preferred provider cost sharing***;
b. Subject to the ***preferred provider*** out-of-pocket expense limit; and
c. Paid based on the lesser of the ***qualifying payment amount*** or the ***nonpreferred provider's*** actual charge; or when applicable:

i. In a State that has in effect an applicable specified State law, the amount determined in accordance with such law; or
ii. In a State that has an all-payer model agreement that applies to this ***Plan***, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

The ***covered person's cost sharing*** will be calculated based on the lesser of the ***qualifying payment amount*** or the billed amount, and ***nonpreferred providers*** may not balance bill for amounts in excess of the ***covered person's cost sharing***. If the ***out-of-network rate*** exceeds the lesser of the ***qualifying payment amount*** or the billed amount, the difference will not be subject to the deductible.

4. Open Negotiation Period

a. A ***nonpreferred provider*** may initiate an open negotiation period with this ***Plan*** regarding ***covered expenses*** as described above. This open negotiation period must be initiated during the thirty (30) business day period beginning on the day the ***nonpreferred provider*** receives an initial payment or a notice of denial of payment for ***covered expenses*** as described above. To initiate the open negotiation period, the ***nonpreferred provider*** must send notice, consistent with applicable regulations, to this ***Plan*** on a standard form developed by Federal regulators.
b. The day on which the open negotiation notice is sent by the ***nonpreferred provider*** is the date the thirty (30) business day open negotiation period begins. Any additional payment amount agreed upon during the open negotiation period must be made by this ***Plan*** within thirty (30) days of such agreement and will not be subject to additional ***cost sharing***.

5. Independent Dispute Resolution

a. In the case of failed negotiations, the ***nonpreferred provider*** or this ***Plan*** may initiate the Federal independent dispute resolution (IDR) process established under the No Surprises Act. The IDR process must be initiated, consistent with applicable Federal regulations, within four (4) business days beginning on the thirty-first (31) business day after the start of the open negotiation period.

b. Within thirty (30) days after the date a ***certified IDR entity*** is selected, such entity must select a payment amount and notify this ***Plan*** and the ***nonpreferred provider*** of the determination. In the absence of a fraudulent claim or evidence of intentional misrepresentation of material facts presented to the ***certified IDR entity***, the decision by such entity is binding on all involved parties.

c. Any additional payment amount due from this ***Plan*** resulting from the decision of the ***certified IDR entity***:

i. Will not be subject to additional ***cost sharing***;
ii. Must be paid within thirty (30) days of such determination; and
iii. Will result in this ***Plan*** being responsible for payment of all fees properly charged by the ***certified IDR entity***.

d. If the ***certified IDR entity*** determines that no additional payment is due to the ***nonpreferred provider*** by this ***Plan***, such provider will be responsible for payment of the ***certified IDR entity*** fee. This ***Plan*** and the ***nonpreferred provider*** will each be responsible for the Federal IDR administrative fee.

e. The ***nonpreferred provider*** and this ***Plan*** may agree on a payment amount for an item or service during the independent dispute resolution process but before the date on which the ***certified IDR entity*** makes a final payment determination. Such amount will be treated as the ***out-of-network rate*** and to the extent this amount exceeds the initial payment amount and any ***cost sharing*** amount, the ***Plan*** must pay the additional amount to the ***nonpreferred provider*** within thirty (30) business days from the date the agreement is reached. This ***Plan*** will be responsible for payment of half of all fees charged by the ***certified IDR entity***, unless this ***Plan*** and the ***nonpreferred provider*** otherwise agree in writing.

6. Notice and Consent Criteria

a. In order to satisfy the Notice and Consent Criteria, a ***nonpreferred provider*** must provide the ***covered person*** with a written notice in paper or electronic form, as selected by the ***covered person***, that is physically separate from other documents and contains the following information:

i. Notification that the health care provider is a ***nonpreferred provider***;
ii. Notification of the good faith estimate amount that the ***nonpreferred provider*** may charge for the items and services, including a notification that the provision of such estimate does not constitute a contract with respect to the estimated charges;
iii. In the case where a ***nonpreferred provider*** would be furnishing items or services at a ***preferred provider facility***, a list of any ***preferred providers*** at such ***facility*** who are able to furnish the items or services and notification that the ***covered person*** may be referred, at their option, to such a ***preferred provider***;
iv. Information about whether pre-certification or other care management limitations may be required in advance of receiving the items or services.

b. The above information must be provided to a ***covered person***:

i. No later than seventy-two (72) hours prior to the date on which the ***covered person*** is furnished the items or services, when the appointment is scheduled at least seventy-two (72) hours prior; or
ii. On the date the appointment is scheduled, in the case where the appointment is scheduled within seventy-two (72) hours prior to the appointment. When the ***covered person*** is provided with the notice and consent on the same date that the items or services are to be furnished, the notice must be provided no later than three (3) hours prior to furnishing the items or services to which the notice and consent requirements apply.

c. The ***nonpreferred provider*** must obtain consent from the ***covered person*** to be treated by the ***nonpreferred provider*** and must provide a signed copy of such consent to the ***covered person*** through mail or email as selected by the ***covered person*** and provide a copy to the ***claims processor***.

7. Continuity of Care

In certain situations, if a ***preferred provider*** becomes a ***nonpreferred provider***, and the ***covered person*** is a ***continuing care patient***, this ***Plan*** will provide the ***covered person*** with notice and an opportunity to elect continuing care from such provider. This election will allow the ***covered person*** to continue to receive benefits under this ***Plan*** in accordance with the ***preferred provider cost sharing***, beginning on the date of the notice and continuing for a period ending of the earlier of:

a. Ninety (90) days from the date of the notice; or
b. The date on which the ***covered person*** is no longer a ***continuing care patient*** with respect to such provider.

REFERRALS

Referrals to a ***nonpreferred provider*** are covered as ***nonpreferred provider*** services, supplies and treatments. It is the responsibility of the ***covered person*** to assure services to be rendered are performed by ***preferred providers*** in order to receive the ***preferred provider*** level of benefits unless described otherwise under the *Nonpreferred Provider* subsection above.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a ***nonpreferred provider*** where ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits:

1. Diagnostic laboratory and surgical pathology tests referred to a ***nonpreferred provider*** by a ***preferred provider***.

2. ***Medically necessary*** specialty services, supplies or treatments which are not available from a provider within the ***Preferred Provider Organization***.

3. Treatment rendered at a ***facility*** of the uniformed services.

4. Transportation by a ***nonpreferred provider*** ambulance for a condition that meets the definition of ***emergency medical condition***.

5. Lactation counseling providers.

CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Claim administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the ***claim administrator*** is a party, including all persons covered under the ***Plan***. Under certain circumstances described in its contracts with Administrator Providers, the ***claim administrator*** may:

- Receive substantial payments from Administrator Providers with respect to services rendered to you for which the ***claim administrator*** was obligated to pay the Administrator Provider, or
- Pay Administrator Providers substantially less than their claim charges for services, by discount or otherwise, or
- Receive from Administrator Providers other substantial allowances under the ***claim administrator's*** contracts with them.

In the case of ***hospitals*** and other ***facilities***, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the ***claim administrator*** as described in this ***Plan*** and the calculation of all required deductible and ***coinsurance*** amounts payable by you as described in this ***Plan*** shall be based on the ***negotiated rate*** or provider's claim charge for covered services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable

to your claim or claims. Your ***employer*** has been advised that the ***claim administrator*** may receive such payments, discounts and/or other allowances during the term of the agreement between your ***employer*** and the ***claim administrator***. Neither the ***employer*** nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

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

a. Assume you go into the ***hospital*** for one night and the normal, full amount the ***hospital*** bills for covered services is $1,000. How is the $1,000 bill paid?
b. You personally will have to pay the deductible and ***coinsurance*** amounts set out in this ***Plan***.
c. 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 negotiated rate*** would be reduced by the ADP applicable to your claim. In our example, if the applicable ADP were 30%, the $1,000 ***hospital*** bill would be reduced by 30% to $700 for purposes of calculating your deductible and ***coinsurance*** amounts, and whether you have reached any out-of-pocket or benefit maximums.
d. Assuming you have already satisfied your deductible, you will still have to pay the ***coinsurance*** portion of the $1,000 ***hospital*** bill after it has been reduced by the ADP. In our example, if your ***coinsurance*** obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% ***coinsurance*** is based on the full $1,000 ***hospital*** bill, after it is reduced by the applicable ADP.
e. After taking into account the deductible and ***coinsurance*** amounts, the ***Plan*** will satisfy its portion of the ***hospital*** bill. In most cases, the ***claim administrator*** has a contract with ***hospitals*** that allows the ***Plan*** to pay less, and requires the ***hospital*** to accept less, than the amount of money the ***Plan*** would be required to pay if the ***claim administrator*** did not have a contract with the ***hospital***.

So, in the example we are using, since the full ***hospital*** bill is $1,000, your deductible has already been satisfied, and your ***coinsurance*** is $140, then the ***Plan*** has to satisfy the rest of the ***hospital*** bill, or $860. Assuming the ***claim administrator*** has a contract with the ***hospital***, the ***Plan*** will usually be able to satisfy the $860 bill that remains after your ***coinsurance*** and deductible, by paying less than $860 to the ***hospital***, often substantially less than $860. The ***Plan*** receives, and keeps for its own account, the difference between the $860 bill and whatever the ***Plan*** ultimately pays under the ***claim administrator's*** contracts with Administrator Providers, and neither you nor your ***employer*** are entitled to any part of these savings.

CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

Claim administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the ***claim administrator*** has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the ***claim administrator'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 the ***claim administrator***. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC. Neither the ***employer*** nor you are entitled to receive any portion of such rebates.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the ***claim administrator***, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufactures to cover the administrative costs of processing late payments). The ***claim administrator*** may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates.

BlueCross BlueShield of Illinois

INTER-PLAN ARRANGEMENTS

I. Out-of-Area Services

Overview

The Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area the Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, the Claim Administrator will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

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

When you receive Covered Services outside the Claim Administrator's service area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services, or
- The negotiated price that the Host Blue makes available to the Claim Administrator.

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

a. Suppose you receive Covered Services for an illness while you are on vacation out of state. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the service - the amount applied to your deductible, if any, and your coinsurance percentage - on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The Coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this Plan Document.

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Claim Administrator has used for your claim because they will not be applied after a Claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, the Claim Administrator may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

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

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating Provider, that amount will be the difference between the Provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a Provider's billed charge, you will incur no liability, other than any related patient cost sharing under this agreement.

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

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

E. Non-Participating Healthcare Providers Outside The Claim Administrator's Service Area

1. Member Liability Calculation

   When Covered Services are provided outside of the Claim Administrator's service area by non-participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Plan Document for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

2. Exceptions

   In certain situations, the Claim Administrator may use other payment methods, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount the Claim Administrator will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of Inpatient, Outpatient and Professional Providers, the network is not served by a Host Blue. As such, when

you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost-share amounts/Deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. **You must contact the Claim Administrator to obtain Preauthorization for non-emergency Inpatient services.**

- **Outpatient Services**

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

- **Submitting a Blue Cross Blue Shield Global Core Claim**

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

YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the ***claim administrator*** will not interfere with your relationship with any Provider.

b. The ***claim administrator*** does not itself undertake to furnish health care services, but solely to make payments to providers for the covered services received by you. The ***claim administrator*** is not in any event liable for any act or omission of any provider or the agent or employee of such provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a provider are not provided by the ***claim administrator***. Any contractual relationship between a ***physician*** and an Administrator Provider shall not be construed to mean that the ***claim administrator*** is providing professional service.

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

d. Each provider provides covered services only to you and does not deal with or provide any services to your ***employer*** (other than as an individual ***covered person***) or your ***employer's*** ERISA health benefit program.

BlueCross BlueShield of Illinois

BLUE DISTINCTION OR BLUE DISTINCTION PLUS CENTERS OF TREATMENT (BDCT)

Blue Distinction is a designation awarded by Blue Cross Blue Shield companies to health care ***facilities*** that have demonstrated expertise in delivering quality health care. At the core of the program are Blue Distinction and Blue Distinction Plus Centers for Specialty Care. Blue Distinction and Blue Distinction Plus Centers are recognized for providing distinguished care in the following transplant or benefit specialty areas of:

- Bariatric Surgery
- Cardiac Care
- Hip and Knee Replacement surgery
- Spinal Surgery
- Transplants

The goal of Blue Distinction is to help you find specialty care while enabling and encouraging health care providers to improve the overall quality and cost of care nationwide. Although your plan may require you to receive treatment at a Blue Distinction or Blue Distinction Plus Center to get the highest level of benefits, you may still be covered at a non-Blue Distinction Center, but your out-of-pocket costs will usually be higher.

BlueCross BlueShield of Illinois

MEDICAL EXPENSE BENEFIT

This section describes the ***covered expenses*** of the ***Plan***. All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay***, ***coinsurance*** and ***Essential Health Benefits***/non-***Essential Health Benefits maximum benefit*** provisions as shown on the *Schedule of Benefits*, unless otherwise indicated. Any portion of an expense ***incurred*** by the ***covered person*** for services, supplies or treatment that is greater than the ***customary and reasonable amount*** for ***nonpreferred providers***, except as described in the *Nonpreferred Provider* subsection, under the *Preferred Provider or Nonpreferred Provider* section, or ***negotiated rate*** for ***preferred providers*** will not be considered a ***covered expense*** by the ***Plan***. Specified preventive care expenses will be considered to be ***covered expenses***.

COPAY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment as shown on the *Schedule of Benefits*. The ***covered person*** selects a ***facility*** or a ***professional provider*** and pays the applicable ***copay***. The ***Plan*** pays the remaining ***covered expenses*** at the ***negotiated rate*** for ***preferred providers*** or the ***customary and reasonable amount*** for ***nonpreferred providers***, except as described in the *Nonpreferred Provider* subsection, under the *Preferred Provider or Nonpreferred Provider* section. The ***copay*** must be paid each time a treatment or service is rendered.

The ***copay*** will not be applied toward the following:

- The benefit period deductible.
- The deductible carry-over.

DEDUCTIBLES

The deductible is the dollar amount of ***covered expenses*** which each ***covered person*** or family must have ***incurred*** during each calendar year before the ***Plan*** pays applicable benefits. The deductible amount is shown on the *Schedule of Benefits*. If the ***out-of-network rate*** exceeds the ***recognized amount*** (or the lesser of the billed charges or the ***qualifying payment amount*** for purposes of ***nonpreferred provider*** air ambulance services), the difference will not be subject to the deductible.

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***customary and reasonable amount*** for ***nonpreferred providers*** except as described in the *Nonpreferred Provider* subsection, under the *Preferred Provider or Nonpreferred Provider* section, or the percentage of the ***negotiated rate*** for ***preferred providers***. That percentage is specified on the *Schedule of Benefits*. For ***nonpreferred providers***, the ***covered person*** may be responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount. See the *Nonpreferred Provider* subsection for more details. The ***covered person's*** portion of the ***coinsurance*** is applied to the out-of-pocket expense limit.

OUT-OF-POCKET EXPENSE LIMIT

After the ***covered person*** has incurred an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses***, the ***Plan*** will begin to pay one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit and will not be payable at one hundred percent (100%), even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by the ***Plan***, including charges in excess of the ***customary and reasonable amount*** or ***negotiated rate***, as applicable.

MAXIMUM BENEFIT

The ***maximum benefit*** for all non-***Essential Health Benefits*** payable on behalf of a ***covered person*** is shown on the *Schedule of Benefits*. The non-***Essential Health Benefits maximum benefit*** applies to the entire time the ***covered person*** is covered under the ***Plan***, either as an ***employee***, ***dependent***, ***alternate recipient*** or under COBRA. If the ***covered person's*** coverage under the ***Plan*** terminates and at a later date the ***covered person*** again becomes covered under the ***Plan***, the non-***Essential Health Benefits maximum benefit*** will include all benefits paid by the ***Plan*** for the ***covered person*** during any period of coverage.

The *Schedule of Benefits* may contain separate ***maximum benefit*** limitations for specified conditions and/or services. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under the ***Plan***. No more than the ***Essential Health Benefits***/non-***Essential Health Benefits maximum benefit*** will be paid for any ***covered person*** while covered by the ***Plan***.

Notwithstanding any provision of the ***Plan*** to the contrary, all benefits received by an individual under any benefit option, package or coverage under the ***Plan*** shall be applied toward the applicable ***maximum benefit*** paid by the ***Plan*** for any one ***covered person*** for such option, package or coverage under the ***Plan***, and also toward the ***maximum benefit*** under any other options, packages or coverages under the ***Plan*** in which the individual may participate in the future.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Covered expenses shall include:

1. ***Room and board*** for treatment in a ***hospital***, including ***intensive care units***, cardiac care units and similar ***medically necessary*** accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***customary and reasonable amount*** for ***nonpreferred providers*** except as described in the *Nonpreferred Provider* subsection, under the *Preferred Provider or Nonpreferred Provider* section, and the percentage of the ***negotiated rate*** for ***preferred providers***. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the ***covered person***.

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:

    a. Admission fees, and other fees assessed by the ***hospital*** for rendering services, supplies and treatments;
    b. Use of operating, treatment or delivery rooms;
    c. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital***;
    d. Medical and surgical dressings and supplies, casts and splints;
    e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
    f. Drugs and medicines (except drugs not used or consumed in the ***hospital***);
    g. X-ray and diagnostic laboratory procedures and services;
    h. Oxygen and other gas therapy and the administration thereof;
    i. Therapy services.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility***, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Charges for pre-admission testing (x-rays and lab tests) performed within seven (7) days prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement***. Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not ***medically necessary***. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted.

AMBULANCE SERVICES

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the ***covered person*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such transportation is certified by the attending ***physician*** as ***medically necessary***. Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

3. ***Emergency services*** actually provided by an advance life support unit, even though the unit does not provide transportation.

If the ***covered person*** is admitted to a ***nonpreferred hospital*** after treatment for an ***emergency medical condition***, ambulance service is covered to transport the ***covered person*** from the ***nonpreferred hospital*** to a ***preferred hospital*** after the patient's condition has been ***stabilized***, provided such transport is certified by the attending ***physician*** as ***medically necessary***.

EMERGENCY SERVICES/EMERGENCY ROOM SERVICES

Covered expenses for ***emergency services*** in the emergency department of a ***hospital*** shall be paid in accordance with the *Schedule of Benefits*. ***Emergency services*** by a ***nonpreferred provider*** shall be paid as specified in the section, *Preferred Provider or Nonpreferred Provider*, under the subsection, *Nonpreferred Provider*.

Covered expenses do not include emergency room treatment for conditions that do not meet the definition of ***emergency medical condition***.

The emergency room ***copay*** shall be waived if the patient is admitted directly into the ***hospital***.

URGENT CARE CENTER

Covered expenses shall include charges for treatment in an ***urgent care center***, payable as specified on the *Schedule of Benefits*.

PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES

Covered expenses shall include the following services when performed by a ***physician*** or a ***professional provider***:

1. Medical treatment, services and supplies including, but not limited to: office visits, ***inpatient*** visits, ***retail clinic*** visits, and home visits.

2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   For related operations or procedures performed through the same incision or in the same operative field, ***covered expenses*** shall include the surgical allowance for the highest paying procedure, plus fifty percent (50%) of the surgical allowance for each additional procedure.

   When two (2) or more unrelated operations or procedures are performed at the same operative session, ***covered expenses*** shall include the surgical allowance for each procedure.

3. Surgical assistance provided by a ***physician*** or ***professional provider*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance. ***Covered expenses*** for the services of an assistant surgeon are limited to twenty percent (20%) of the surgical allowance.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office.

5. Consultations requested by the attending ***physician*** during a ***hospital confinement***. Consultations do not include staff consultations that are required by a ***hospital's*** rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory tests, electronic tests, pathology, ultrasound, nuclear medicine, magnetic imaging and x-rays.

TRANSPLANT

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is covered under the ***Plan***, the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When the donor is covered under the ***Plan***, the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant, provided the recipient is also covered under the ***Plan***. ***Covered expenses incurred*** by each person will be considered separately for each person.

3. Expenses ***incurred*** by the donor who is not ordinarily covered under the ***Plan*** according to eligibility requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under the ***Plan***. The donor's expenses shall be applied to the recipient's ***maximum benefit***. In no event will benefits be payable in excess of the ***maximum benefit.***

4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under the ***Plan***.

5. Transportation, lodging and meals for the covered recipient and one (1) other person (two (2) other persons if the recipient is an eligible ***dependent*** child) to accompany the recipient to and from a ***facility*** and for lodging and meals at or near the ***facility*** where the recipient is confined, up to any non-***Essential Health Benefits maximum benefit*** specified on the *Schedule of Benefits*.

If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Centers of Medical Excellence (CME) and Blue Distinction Centers for Transplants (BDCT)

In addition to the above transplant benefits, the ***covered person*** may be eligible to participate in a Centers of Medical Excellence (CME) and Blue Distinction Centers for Transplants (BDCT). ***Covered persons*** should contact the ***Health Care Management Organization*** to discuss this benefit by calling 1-800-480-6658.

A Centers of Medical Excellence (CME) and Blue Distinction Centers for Transplants (BDCT) are ***facilities*** within a Centers of Excellence Network that has been chosen for its proficiency in performing one or more transplant

procedures. Usually located throughout the United States, the Centers of Medical Excellence (CME) and Blue Distinction Centers for Transplants (BDCT) ***facilities*** have greater transplant volumes and surgical team experience than other similar ***facilities***.

Transplant procedures are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits for the ***hospital confinement*** as specified in the *Claim Filing Procedure* section of this document.

PREGNANCY

Covered expenses shall include services, supplies and treatment related to ***pregnancy*** or ***complications of pregnancy*** for a covered pregnant ***employee*** or a covered pregnant spouse of a covered ***employee***.

The ***Plan*** shall cover services, supplies and treatments for abortions (where legal); and where the life of the mother would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion pursuant to the Pregnancy Discrimination Act if applicable.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of the ***physician's*** license and the ***birthing center*** meets all legal requirements. Services of a midwife acting within the scope of the midwife's license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

STERILIZATION

Covered expenses shall include elective surgical sterilization procedures for the covered male ***employee*** or covered male spouse. ***Covered expenses*** for elective surgical sterilization procedures for women shall be considered under the subsection, *Women's Preventive Services*. Reversal of surgical sterilization is not a ***covered expense***.

INFERTILITY SERVICES

Covered expenses shall include expenses for infertility testing for ***employees*** and their covered spouse.

Covered expenses for infertility testing are limited to the actual testing for a diagnosis of infertility. Any outside intervention procedures (*e.g.*, artificial insemination) will not be considered a ***covered expense***.

CONTRACEPTIVES

Covered expenses shall include charges for medical procedures or supplies related to contraception, including screening, education, counseling, oral contraceptives, contraceptive devices, contraceptive injections and the surgical implantation and removal of contraceptive devices. FDA approved contraceptive methods shall be considered under the subsection, *Women's Preventive Services*.

Charges for contraceptives that require a prescription and are dispensed by a pharmacy are covered under the *Prescription Drug Program*.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care as part of the birth parent's claim not to exceed four (4) days.

Such care shall include, but is not limited to:

1. ***Physician*** services

2. ***Hospital*** services

3. Circumcision

ROUTINE PREVENTIVE CARE/WELLNESS BENEFITS

Routine Preventive Care/Wellness Benefits shall include:

1. Evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).

2. Annual routine mammograms for women.

3. Colonoscopies, and follow-up colonoscopies conducted after a positive non-invasive stool-based screening test or direct visualization screening test, including pre-procedure consultation, bowel preparation kits and pathology exam, for adults.

4. Routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention for infants and children through age six (6); children and adolescents age seven (7) through eighteen (18) years and adults age nineteen (19) years and older.

5. Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration for infants, children, adolescents and adult women, unless included in the USPSTF recommendations.

6. Screening for tobacco use and two (2) tobacco cessation attempts per year and tobacco cessation medications for a ninety (90) day treatment regimen when prescribed by a ***physician.***

The ***Plan*** will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

WOMEN'S PREVENTIVE SERVICES

Covered expenses shall include preventive services recommended in guidelines issued by the U.S. Department of Health and Human Services' Health Resources and Services Administration, including, but not limited to:

1. Annual well-woman office visits to obtain preventive care and pregnancy, prenatal, postpartum and interpregnancy office visits;

2. Screening for gestational diabetes in a pregnant woman;

3. Human papillomavirus (HPV) DNA testing no more frequently than every three (3) years for a woman age thirty (30) and above;

4. Annual counseling for sexually transmitted infections for a sexually active woman;

5. Annual counseling and screening for human immune deficiency virus for a sexually active woman;

6. FDA approved contraceptive methods, sterilization procedures and patient education, screening and counseling for a woman with reproductive capacity;

7. Breastfeeding support, supplies and counseling, to include the cost of rental or purchase, whichever is less costly, of breastfeeding equipment;

8. Annual screening and counseling for interpersonal and domestic violence; and

9. Genetic counseling for women identified to be at higher risk of having a potentially harmful gene mutation, and, if indicated, BRCA testing for harmful BRCA mutations.

The ***Plan*** will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

ROUTINE PROSTATE EXAMINATIONS

Covered expenses shall include routine prostate examinations and routine prostate specific antigen (PSA) tests, for men.

THERAPY SERVICES

Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury*** or for congenital anomaly.

Covered expenses shall include:

1. Services of a ***professional provider*** for physical therapy, occupational therapy, speech therapy or respiratory therapy.
2. Radiation therapy and chemotherapy.
3. Dialysis therapy or treatment.
4. Infusion therapy.
5. Vision therapy (orthoptics).

Outpatient therapy services are subject to the ***Essential Health Benefits maximum benefit*** specified on the *Schedule of Benefits*.

HABILITATIVE SERVICES

Covered expenses shall include ***medically necessary habilitative services*** to help a ***covered person*** keep, learn or improve skills and functioning for daily living. Examples of ***habilitative services*** include therapy for a ***dependent*** child who is not walking or talking at the expected age. Services may include physical, occupational and speech therapy.

EXTENDED CARE FACILITY

Extended care facility services, supplies and treatments shall be a ***covered expense*** provided the ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***extended care facility***) limited to the ***facility's*** average ***semiprivate room*** rate; and
2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

Extended care facility benefits are subject to the ***Essential Health Benefits maximum benefit*** specified on the *Schedule of Benefits*.

HOME HEALTH CARE

Home health care enables the ***covered person*** to receive treatment in the ***covered person's*** home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility***. ***Covered expenses*** shall include the following services and supplies provided by a ***home health care agency***:

1. Part-time or intermittent nursing care by a ***nurse***;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent ***home health aide services*** for a ***covered person*** who is receiving covered nursing or therapy services;
4. Medical social service consultations;
5. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.

Covered expenses shall be subject to the ***Essential Health Benefits maximum benefit*** specified on the *Schedule of Benefits*.

A visit by a member of a ***home health care*** team and four (4) hours of ***home health aide service*** will each be considered one (1) ***home health care*** visit.

No ***home health care*** benefits will be provided for dietitian services (except as may be specifically provided herein), homemaker services, maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of ***durable medical equipment*** or prescription or non-prescription drugs or biologicals.

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered at home, in ***outpatient*** settings, or in ***facility*** settings for a ***covered person*** suffering from a condition that has a terminal prognosis.

Hospice care will be covered only if the ***covered person's*** attending ***physician*** certifies that:

1. The ***covered person*** is terminally ill, and
2. The ***covered person*** has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board***.
2. Services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.
3. ***Physician*** services and/or nursing care by a ***nurse***.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.
5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.
6. Counseling services provided through the ***hospice***.
7. Respite care by an aide who is employed by the ***hospice*** for up to four (4) hours per day. (Respite care provides care of the ***covered person*** to allow temporary relief to family members or friends from the duties of caring for the ***covered person***).

Charges ***incurred*** during periods of remission are not eligible under this provision of the ***Plan***. Any ***covered expense*** paid under ***hospice*** benefits will not be considered a ***covered expense*** under any other provision of the ***Plan***.

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly (except as noted below for oxygen concentrators), of ***medically necessary durable medical equipment*** which is prescribed by a ***qualified prescriber*** and required for therapeutic use by the ***covered person*** shall be a ***covered expense***.

A charge for the purchase or rental of ***durable medical equipment*** is considered ***incurred*** on the date the equipment is received/delivered. ***Durable medical equipment*** that is received/delivered after the termination date of a ***covered person's*** coverage under the ***Plan*** is not covered. Repair or replacement of purchased ***durable medical equipment*** which is ***medically necessary*** due to normal use or a physiological change in the patient's condition will be considered a ***covered expense***.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the ***covered person's*** medical needs.

Ongoing rental charges for oxygen concentrators shall be a ***covered expense***, provided the equipment is determined to be ***medically necessary*** for the treatment of chronic conditions or upon diagnosis of severe lung disease or other hypoxia related symptoms or findings.

Covered expenses for the rental of breastfeeding equipment shall be considered under the subsection, *Women's Preventive Services*.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a ***covered expense***. A charge for the purchase of a prosthesis is considered ***incurred*** on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of a ***covered person's*** coverage under the ***Plan*** is not covered. Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or a physiological change in the patient's condition will be considered a ***covered expense***.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device, including custom/molded foot orthotics, which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury***. Treatment must be completed within twelve (12) months of the ***injury***. Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Surgical removal of bone or soft tissue impacted wisdom teeth shall also be considered a ***covered expense***.

Covered expenses shall include charges for oral surgery such as completely unerupted impacted teeth, excision of the entire tooth, closed or open reduction of fractures or dislocations of the jaw, and other incision or excision procedures performed on the gums and tissues of the mouth when not performed in conjunction with the extraction of teeth.

Facility charges for oral surgery or dental treatment that ordinarily could be performed in the provider's office will be covered only if the ***covered person*** has a chronic disease or condition for which treatment in a ***facility*** is determined by the ***Plan*** to be ***medically necessary***, or if the age of the ***covered person*** prohibits performing the treatment safely in an office setting.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and non-surgical treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome shall be a ***covered expense***.

ORTHOGNATHIC DISORDERS

Surgical and non-surgical treatment of orthognathic disorders shall be a ***covered expense***, but shall not include orthodontia or prosthetic devices even if prescribed by a ***qualified prescriber***. This limitation shall apply whether treatment is provided by a ***hospital***, ***physician***, ***dentist***, physical therapist or oral surgeon.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to:

- casts;
- splints;
- braces;
- trusses;
- surgical and orthopedic appliances;
- colostomy and ileostomy bags and supplies required for their use;
- catheters;
- allergy serums;
- crutches;
- electronic pacemakers;
- oxygen and the administration thereof;
- the initial pair of eyeglasses or contact lenses due to cataract surgery;
- soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye;
- support or compression stockings, when prescribed by a ***physician***;
- a wig or hairpiece when required due to chemotherapy, radiation therapy, surgery or burns, limited to the non-***Essential Health Benefits maximum benefit*** as stated on the *Schedule of Benefits*;
- surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

COSMETIC/RECONSTRUCTIVE SURGERY

Cosmetic surgery or ***reconstructive surgery*** shall be a ***covered expense*** provided:

1. A ***covered person*** receives an ***injury*** as a result of an ***accident*** and as a result requires surgery. ***Cosmetic*** or ***reconstructive surgery*** and treatment must be for the purpose of restoring the ***covered person*** to his normal function immediately prior to the ***accident***.

2. It is required to correct a congenital anomaly, for example, a birth defect.

GENDER DYSPHORIA

Covered expenses shall include treatment provided by a ***professional provider*** for gender dysphoria, a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Treatment includes ***medically necessary*** psychotherapy, hormone therapy, prescription drugs and surgery. Cosmetic services, including the following, are not covered:

1. Abdominoplasty;
2. Blepharoplasty;
3. Breast enlargement, including augmentation mammoplasty and breast implants;
4. Body contouring such as lipoplasty or liposuction;
5. Brow lift;
6. Calf implants;
7. Cheek, chin, nose implants;
8. Electrolysis;
9. Injection of fillers or neurotoxins;
10. Face lift, forehead lift or neck tightening;
11. Facial bone remodeling;
12. Hair removal;
13. Hair transplantation;
14. Jaw reduction or jaw contouring;
15. Laryngoplasty;
16. Lip augmentation;
17. Lip reduction;
18. Mastopexy;
19. Pectoral implants for chest masculinization;
20. Removal of redundant skin;
21. Rhinoplasty;
22. Skin resurfacing;
23. Thyroid cartilage reduction;
24. Voice modification surgery;
25. Voice lessons and voice therapy.

MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)

The ***Plan*** intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

Covered expenses will include eligible charges related to ***medically necessary*** mastectomy.

For a ***covered person*** who elects breast reconstruction in connection with such mastectomy, ***covered expenses*** will include:

1. reconstruction of a surgically removed breast, including nipple and areola reconstruction and repigmentation; and

2. surgery and reconstruction of the other breast to produce a symmetrical appearance.

An external breast prosthesis shall be covered once every three (3) calendar years, unless recommended more frequently by a ***physician***. The first permanent internal breast prosthesis necessary because of a mastectomy shall also be a ***covered expense***.

Prostheses (and ***medically necessary*** replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered ***covered expenses*** following all ***medically necessary*** mastectomies.

MENTAL HEALTH DISORDERS

The ***Plan*** will pay for ***medically necessary covered expenses*** for ***inpatient*** and ***outpatient*** treatment, services or supplies for the treatment of ***mental health disorders***.

Covered expenses shall include:

1. ***Inpatient hospital confinement***;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider***.

SUBSTANCE USE DISORDER

The ***Plan*** will pay for ***medically necessary covered expenses*** for the ***inpatient*** and ***outpatient*** treatment of ***substance use disorder*** in a ***hospital*** or ***treatment center*** by a ***physician*** or ***professional provider***.

AUTISM SPECTRUM DISORDERS

Covered expenses shall include services, supplies and treatment for ***autism spectrum disorders*** performed by a ***physician*** or a ***professional provider*** that are focused on behavioral intervention, such as ***Applied Behavioral Analysis*** (ABA) evaluation and therapy and behavioral services that are focused on primary building skills and capabilities in communication, social interaction and learning.

PRESCRIPTION DRUGS

The ***Plan*** shall cover prescription drugs approved by the Food and Drug Administration dispensed by a ***physician*** or ***dentist***. Antigen and allergy vaccine dispensed by a ***physician*** or certified laboratory shall be a ***covered expense***.

Prescription drugs dispensed in a provider's office shall be considered a ***covered expense*** under this *Medical Expense Benefit*.

The application of ***copays*** or deductibles under the *Prescription Drug Program* shall not be considered a ***covered expense*** under the *Medical Expense Benefit*.

ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS

Covered expenses shall include charges for "routine patient costs" incurred by a "qualified individual" participating in an ***approved clinical trial***. "Routine patient costs" do not include:

1. An investigational item, device or service;

2. An item or service provided solely to satisfy data collection and analysis needs, which 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.

"Life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Qualified Individual" means a ***covered person*** who is eligible to participate in an ***approved clinical trial*** according to the trial protocol with respect to the treatment of cancer or another "life-threatening disease or condition" and either;

1. The referring health care professional is a participating health care ***provider*** and has concluded that the ***covered person's*** participation in such trial would be appropriate; or,

2. The ***covered person*** provides medical and scientific information establishing that the ***covered person's*** participation in such trial would be appropriate.

"Routine patient costs" include all items and services consistent with the coverage provide by the ***Plan*** that is typically covered for a c***overed person*** who is not enrolled in a clinical trial.

PHASE III ONCOLOGY CLINICAL TRIALS

Covered expenses shall include charges for a drug, device, supply, treatment, procedure or service that is part of a scientific study of cancer therapy in a Phase III clinical trial sponsored by the National Cancer Institute or institution of similar stature. Trials must have Institutional Review Board (IRB) approval by a qualified IRB. Charges that are not covered include:

1. Costs for services that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).

2. Costs for services provided in a clinical trial that are funded by another source.

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

HEARING BENEFIT

Prescription hearing aids are a ***covered expense***, subject to the non-***Essential Health Benefits maximum benefit*** as specified on the *Schedule of Benefits*. ***Covered expenses*** shall include ***medically necessary*** cochlear implants and bone anchored hearing aids.

ACUPUNCTURE

Acupuncture performed to induce surgical anesthesia or for therapeutic purposes shall be a ***covered expense,*** subject to the non-***Essential Health Benefits maximum benefit*** as specified on the *Schedule of Benefits*.

PRIVATE DUTY NURSING

Medically necessary services of a private duty ***nurse*** on an ***outpatient*** basis only shall be a ***covered expense***.

Coverage for ***medically necessary*** private duty nursing shall be subject to the non-***Essential Health Benefits maximum benefit*** specified on the *Schedule of Benefits*.

CHIROPRACTIC CARE

Covered expenses include initial consultation, x-rays and treatment (but not maintenance care), subject to the non-***Essential Health Benefits maximum benefit*** shown on the *Schedule of Benefits*.

PATIENT EDUCATION

Covered expenses shall include ***medically necessary*** patient education programs including, but not limited to diabetic education and ostomy care.

Covered expenses for patient education for contraception or lactation training shall be considered under the subsection, *Women's Preventive Services*.

SURCHARGES

Any surcharge or assessment (by whatever name called) on ***covered expenses***, required by state or federal law to be paid by the ***Plan*** for services, supplies and/or treatments rendered by a health care provider shall be a ***covered expense*** subject to the ***covered person's*** obligations under the ***Plan***.

OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS

Covered expenses shall include charges for qualified ***medically necessary outpatient*** cardiac/pulmonary rehabilitation programs.

WEIGHT MANAGEMENT

Surgical Treatment for Weight Loss

Covered expenses shall include ***medically necessary*** surgical treatment for weight loss, including but not limited to gastric by-pass, gastric stapling or gastric balloon.

Non-Surgical Treatment for Weight Loss

Covered expenses shall include ***medically necessary*** non-surgical treatment for weight loss that is administered and supervised by a ***physician***. This program must not be a weight reduction program, but a program designed to treat health problems associated with high-risk obesity. These health conditions may include hypertension, diabetes, cardiovascular disease, sleep apnea and degenerative joint disease. This program does not include any athletic or fitness center membership or training.

SLEEP DISORDERS

Covered expenses shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

TELEMEDICINE SERVICES

Covered expenses shall include ***telemedicine services*** provided through a designated ***telemedicine services vendor*** for ***medically necessary*** treatment of non-***emergency medical conditions.***

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MEDICAL EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under the ***Plan*** for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of surgical sterilization procedures.

2. Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate birth parent (unless the surrogate is a ***covered person***, in which case expenses under subsection *Woman's Preventive Services* and/or *Pregnancy*, will be covered in accordance with this ***Plan's*** provisions), fertility drugs, embryo implantation, or gamete intrafallopian transfer (GIFT).

3. Charges for treatment or surgery for sexual dysfunction or inadequacies.

4. Charges for ***hospital*** admission on Friday, Saturday or Sunday unless the admission is due to an ***emergency medical condition***, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.

5. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary***.

6. Charges for services, supplies or treatment for attention deficit disorders, behavior or conduct disorders, hyperactivity, learning disorders, intellectual disability, or senile deterioration. However, the initial examination, office visit and diagnostic testing to determine the ***illness*** shall be a ***covered expense***.

7. Charges for biofeedback therapy.

8. Except as specified herein, charges for services, supplies or treatments which are primarily educational in nature, charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for training or other forms of education.

9. Charges for marriage, career or legal counseling.

10. Except as specifically stated in *Medical Expense Benefit, Dental Services*, charges for or in connection with: treatment of ***injury*** or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

11. Charges for routine vision examinations and eye refractions; eyeglasses or contact lenses, except as specified herein; dispensing optician's services.

12. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

13. Except as ***medically necessary*** for the treatment of metabolic or peripheral-vascular ***illness***, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

14. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician***, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.

15. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements except as provided in, *Routine Preventive Care/Wellness Benefits* in accordance with United States Preventive Services Task Force (USPSTF) recommendations.

16. Any prescription refilled in excess of the number specified by the ***physician*** or any refill dispensed after one (1) year from the ***physician's*** original order.

17. Charges for ***outpatient*** prescription drugs, except as specifically indicated in *Medical Expense Benefit*.

18. Charges for prescription drugs that are covered under the *Prescription Drug Program*.

19. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts except as specified herein.

20. Expenses for a ***cosmetic surgery*** or procedure and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic/Reconstructive Surgery*.

21. Charges ***incurred*** as a result of, or in connection with, any procedure or treatment excluded by the ***Plan*** which has resulted in medical complications.

22. Charges ***incurred*** as a result of, or in connection with, any procedure or treatment excluded by the ***Plan*** which has resulted in medical complications, except for complications from a non-covered abortion as specified herein.

23. Charges for non-surgical treatment for weight loss including but not limited to: non-***physician*** supervised exercise programs or use of exercise equipment; special diets or diet foods, or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and any overnight stays at any exercise programs or ***hospital confinements*** for weight reduction programs except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations, and except as specifically indicated in the *Medical Expense Benefit, Weight Management, Non-Surgical Treatment for Weight Loss* subsection.

24. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

25. Notwithstanding anything in the ***Plan*** to the contrary, the ***Plan*** will not cover charges related to hearing aids that do not require a prescription.

26. Charges for employment physicals, sports physicals, preschool or school examinations, or any related charges, and other care not associated with treatment or diagnosis of an ***illness*** or ***injury***, except as specified herein.

27. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid except when specifically stated in the *Medical Expense Benefit*. Notwithstanding anything in the ***Plan*** to the contrary, the ***Plan*** will not cover charges related to hearing aids that do not require a prescription.

28. Except as specifically stated in *Medical Expense Benefit, Temporomandibular Joint Dysfunction*, charges for treatment of temporomandibular joint dysfunction and myofascial pain syndrome including, but not limited to: charges for treatment to alter vertical dimension or to restore abraded dentition, and orthodontia.

29. Charges for ***custodial care***, domiciliary care or rest cures.

30. Charges for travel or accommodations, whether or not recommended by a ***physician***, except as specifically provided herein.

31. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness or stimulate hair growth, except as specified herein.

32. Charges for expenses related to hypnosis.

33. Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not a ***covered person*** under the ***Plan***.

34. Charges for professional services billed by a ***professional provider*** who is an employee of a ***hospital*** or any other ***facility*** and who is paid by the ***hospital*** or other ***facility*** for the service provided.

35. Charges for environmental change including ***hospital*** or ***physician*** charges connected with prescribing an environmental change.

36. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example).

37. Charges for chelation therapy, except as treatment of heavy metal poisoning.

38. Charges for massage therapy, sex therapy, diversional therapy or recreational therapy.

39. Charges for procurement and storage of one's own blood, unless ***incurred*** within three (3) months prior to a scheduled surgery.

40. Charges for holistic medicines or providers of naturopathy.

41. Charges for or related to the following types of treatment:

    a. primal therapy;
    b. rolfing;
    c. psychodrama;
    d. megavitamin therapy;
    e. visual perceptual training.

42. Charges for structural changes to a house or vehicle.

43. Charges for exercise programs for treatment of any condition, except as specified herein.

44. Charges for immunizations required for travel except as provided in accordance with USPSTF recommendations.

45. Charges for drugs, devices, supplies, treatments, procedures or services that are considered ***experimental/investigational*** by the ***Plan***. The ***Plan*** will consider a drug, device, supply, treatment, procedure or service to be "***experimental***" or "***investigational***":

    a. if, in the case of a drug, device or supply, the drug, device or supply cannot be lawfully marketed without approval of the U.S. Food and drug Administration and approval for marketing has not been given at the time the drug, device or supply is furnished; or
    b. if the drug, device, supply, treatment, procedure or service, or the patient's informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service was reviewed and approved by the treating ***facility's*** institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
    c. if the ***plan sponsor*** (or its designee) determines in its sole discretion that the drug, device, supply, treatment, procedure or service is the subject of on-going Phase I or Phase II clinical trials; is the research, ***experimental*** study or ***investigational*** arm of on-going Phase III clinical trials , or is otherwise under study to determine maximum tolerated dose, toxicity, safety or efficacy, however, a drug, device, supply, treatment, procedure or service that meets the standards set in the section *Medical Expense Benefit Phase III Oncology Clinical Trials* will not be deemed ***experimental*** or ***investigational*** solely by reason of this subparagraph ; or
    d. if the ***plan sponsor*** (or its designee) determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.

46. Charges for ***inpatient*** private duty nursing.

47. Charges for any services, supplies or treatment not specifically provided herein.

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PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

Participating pharmacies have contracted with the ***Plan*** to charge ***covered persons*** reduced fees for covered prescription drugs.

PHARMACY OPTION COINSURANCE

The ***coinsurance*** is applied to each covered pharmacy drug charge and is shown on the *Schedule of Benefits*. The ***coinsurance*** amount is not a ***covered expense*** under the *Medical Expense Benefit*. Any one prescription is limited to a thirty (30) day supply. Maintenance drugs (drugs which are prescribed for long-term usage) may be dispensed in a ninety (90) day supply.

If a drug is purchased from a ***nonparticipating pharmacy*** or a ***participating pharmacy*** when the ***covered person's*** ID card is not used, the ***covered person*** must pay the entire cost of the prescription, including ***copay***, and then submit the receipt to the prescription drug card vendor for reimbursement. If a ***nonparticipating pharmacy*** is used, the ***covered person*** will be responsible for the ***coinsurance***, plus the difference in cost between the ***participating pharmacy*** and ***nonparticipating pharmacy***.

If the ***covered person*** purchases a brand drug when a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested, plus the brand ***coinsurance***. The ***covered person*** may appeal the ***adverse benefit determination***. Refer to the subsection, *Appealing an Adverse Benefit Determination on a Post-Service Prescription Drug Claim*, for detailed information on how to initiate the appeal process. This difference between the cost of the brand name drug and the ***generic drug*** shall not accumulate toward the out-of-pocket limit.

When the out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs which may be prescribed for heart disease, high blood pressure, asthma, etc.).

MAIL ORDER OPTION COINSURANCE

The ***coinsurance*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits*. The ***coinsurance*** is not a ***covered expense*** under the *Medical Expense Benefit*. Any one prescription is limited to a ninety (90) day supply.

If the ***covered person*** purchases a brand drug when a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested, plus the brand ***coinsurance***. The ***covered person*** may appeal the ***adverse benefit determination***. Refer to the subsection, *Appealing an Adverse Benefit Determination on a Post-Service Prescription Drug Claim*, for detailed information on how to initiate the appeal process. This difference between the cost of the brand name drug and the ***generic drug*** shall not accumulate toward the out-of-pocket limit.

When the out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

COVERED PRESCRIPTION DRUGS

1. Drugs prescribed by a ***qualified prescriber*** that require a prescription either by federal or state law, including injectables and insulin, except drugs excluded by the ***Plan***,

2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Diabetic medication:
   Insulin;
   Insulin needles and syringes;
   Glucagon;
   Glucose Test Strips;
   Lancets
   Diabetic Supplies

4. Proton pump inhibitors.

5. Contraceptives.

6. Routine preventive drugs as required by the ***Affordable Care Act***.

7. Drugs used in the treatment of sexual dysfunction.

8. Weight loss drugs.

9. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a ***qualified prescriber***.

LIMITS TO THIS BENEFIT

This benefit applies only when a ***covered person*** incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician***.

2. Refills up to one year from the date of order by a ***physician***.

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin or routine preventive drugs as required by the ***Affordable Care Act***.

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

3. A charge for allergy serums and testing materials.

4. Immunization agents or biological sera, blood or blood plasma.

5. A drug or medicine labeled: “Caution - limited by federal law to ***investigational*** use.”

6. ***Experimental*** drugs and medicines, even though a charge is made to the ***covered person***.

7. Any charge for the administration of a covered prescription drug.

8. A charge for prescription medication with OTC equivalents. Any drug or medicine that is consumed or administered at the place where it is dispensed.

9. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital*** confined. This includes being confined in any institution that has a ***facility*** for dispensing drugs.

10. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

11. A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than insulin).

12. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

13. A charge for infertility medication.

14. A charge for legend vitamins, except pre-natal legend vitamins.

15. A charge for minerals.

16. A charge for dietary formulas for treatment of phenylketonuria or other heritable diseases.

17. A charge for fluoride supplements, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

18. A charge for medications that are cosmetic in nature (*i.e.*, treating hair loss, wrinkles, etc.).

19. A charge for growth hormones.

20. A charge Retin A or pharmacologically similar topical drugs.

21. A charge for non-sedating antihistamine (NSA) drugs and combination medications containing an NSA and decongestant.

22. A charge for Levonorgestrel (Norplant implants).

23. A charge for Hematinics.

24. A charge for non-legend drugs, other than as specifically listed herein or as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

Any prescription drug covered under the *Prescription Drug Program* will not be covered under the *Medical Expense Benefit*, except as specified in *Medical Expense Benefit, Prescription Drugs*.

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***covered person*** may provide the ***plan administrator*** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to the release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resources Department.

APPEALING AN ADVERSE BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG CLAIM

The "***named fiduciary***" for purposes of an appeal of an ***adverse benefit determination*** on a Post-Service Prescription Drug Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor***.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of an ***adverse benefit determination*** on a Post-Service prescription drug claim by making written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the ***adverse benefit determination*** and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person*** for a full and fair review:

1. The ***covered person*** has the right to submit documents, information and comments and to present evidence and testimony.

2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

3. Before a final ***adverse benefit determination*** on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal ***adverse benefit determination*** to give the ***covered person*** an opportunity to respond. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:

   a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.

4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

5. The review by the ***named fiduciary*** will not afford deference to the original ***adverse benefit determination***.

6. The ***named fiduciary*** will not be:

   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.

7. If original ***adverse benefit determination*** was, in whole or in part, based on medical judgment:

   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:

      (i.) An individual who was consulted in connection with the original ***adverse benefit determination***, nor
      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original ***adverse benefit determination***.

8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original ***adverse benefit determination***, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG CLAIM APPEAL

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the ***adverse benefit determination***.

2. Reference to specific ***Plan*** provisions on which the ***adverse benefit determination*** is based.

3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.

5. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:

   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

EXTERNAL APPEAL

The "***named fiduciary***" for purposes of an external appeal of an ***adverse benefit determination*** on a Pre-Service or Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1, is the ***claims processor***.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of an ***adverse benefit determination*** appeal if the claim determination involves medical judgment or a rescission by making written request to the ***claims processor*** within four (4) months of receipt of notification of the ***final internal adverse benefit determination***. Medical judgment includes, but is not limited to:

1. ***Medical necessity***;

2. Appropriateness;

3. ***Experimental*** or ***investigational*** treatment;

4. Health care setting;

5. Level of care; and

6. Effectiveness of a ***covered expense***.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of ***final internal adverse benefit determination***. {*Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.*}

RIGHT TO EXTERNAL APPEAL

Within five (5) business days of receipt of the request, the ***claims processor*** will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the ***final internal adverse benefit determination*** was the result of:

1. Medical judgment; or

2. Rescission of coverage under this ***Plan***.

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NOTICE OF RIGHT TO EXTERNAL APPEAL

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 1-866-444-3272, if the request is complete but not eligible for external review.

2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the ***covered person*** to perfect the external review request by the later of the following:

    a. The four (4) month filing period; or
    b. Within the forty-eight (48) hour time period following the ***covered person's*** receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the ***covered person*** in writing of the request's eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

The assigned IRO shall provide the ***plan administrator*** (or its designee) and the ***covered person*** (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the ***covered person***, the ***Plan*** and ***claims processor***, except to the extent that other remedies may be available under State or Federal law.

EXPEDITED EXTERNAL REVIEW

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) the right to request an expedited external review upon the ***covered person's*** receipt of either of the following:

1. An ***adverse benefit determination*** involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function and the ***covered person*** has filed an internal appeal request.

2. A ***final internal adverse benefit determination*** involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function or if the ***final internal adverse benefit determination*** involves any of the following:

    a. An admission,
    b. Availability of care,
    c. Continued stay, or
    d. A health care item or service for which the ***covered person*** received ***emergency services***, but has not yet been discharged from a ***facility***.

Immediately upon receipt of the request for *Expedited External Review*, the ***Plan*** will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, *Right to External Appeal*.

2. Send notice of the ***Plan's*** decision, as described in the subsection, *Notice of Right to External Appeal*.

Upon determination that a request is eligible for external review, the ***Plan*** will do all of the following:

1. Assign an IRO as described in the subsection, *Independent Review Organization*.

2. Provide all necessary documents or information used to make the ***adverse benefit determination*** or final ***adverse benefit determination*** to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the ***covered person's*** medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the ***plan administrator*** (or its designee) and the ***covered person*** (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

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PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider***.

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, treatment or supplies for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the ***covered person*** fails to claim rights to such benefits or fails to enroll or purchase such coverage. This does not include a ***covered person*** that is a sole proprietor, partner or executive officer that is not required by law to have workers' compensation or similar coverage and does not have such coverage.

5. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury*** or which are not recommended and approved by the attending ***physician***, except as specifically stated herein, or to the extent that the charges exceed the ***customary and reasonable amount***, ***qualifying payment amount*** (subject to the ***out-of-network rate***) or the ***negotiated rate***, as applicable.

6. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during the ***covered person's*** commission or attempted commission of a criminal battery or felony. Claims shall be denied if the ***plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the ***covered person***. This exclusion will not apply to an ***illness*** and/or ***injury*** sustained due to a medical condition (physical or mental) or domestic violence.

7. To the extent that payment under the ***Plan*** is prohibited by any law of any jurisdiction in which the ***covered person*** resides at the time the expense is ***incurred***.

8. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage.

9. Any services, supplies or treatment for which the ***covered person*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

10. Charges for services, supplies and treatment that are considered ***experimental/investigational*** except as specified herein.

11. Charges ***incurred*** outside the United States if the ***covered person*** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

12. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person*** or if the ***covered person*** provides treatment for themselves.

13. Charges for services, supplies or treatment rendered by ***physicians*** or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider***.

14. Charges for ***illnesses*** or ***injuries*** suffered by a ***covered person*** due to the action or inaction of any party if the ***covered person*** fails to provide information as specified in the section, *Subrogation/Reimbursement*.

15. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in the section, *Claim Filing Procedure*.

16. Charges for completion of claim forms and charges associated with missed appointments.

17. This ***Plan*** will not pay for any charge which has been refused by another plan covering the ***covered person*** as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

18. Benefits which are payable under any separate plan sponsored by the ***employer***, whether self-insured of fully-insured, shall not be payable as a benefit under this ***Plan*** and shall not be eligible under the *Coordination of Benefits* section.

19. Charges for services, supplies, care or treatment to a ***covered person*** for an ***injury*** which occurred as a result of that ***covered person's*** illegal use of alcohol. Claims shall be denied if the ***plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records of the ***covered person's*** illegal use of alcohol. Expenses will be covered for injured ***covered persons*** other than the person illegally using alcohol and expenses will be covered for ***substance use disorder*** treatment as specified on the *Schedule of Benefits*. This exclusion does not apply if the ***injury*** resulted from an act of domestic violence or an underlying medical condition.

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ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

Refer to LSC Group Benefits Plan and the LSC Flexible Benefits Plan Summary Plan Description for Eligibility, Enrollment and Effective Date requirements.

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TERMINATION OF COVERAGE

Refer to LSC Group Benefits Plan and the LSC Flexible Benefits Plan Summary Plan Description for termination of coverage details.

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CONTINUATION OF COVERAGE

Refer to LSC Group Benefits Plan and the LSC Flexible Benefits Plan Summary Plan Description for Continuation of coverage details.

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MEDICAL CLAIM FILING PROCEDURE

A "pre-service claim" is a claim for a ***Plan*** benefit that is subject to the pre-certification rules, as described in the section, *Pre-Service Claim Procedure*. All other claims for ***Plan*** benefits are "post-service claims" and are subject to the rules described in the section, *Post-Service Claim Procedure*.

POST-SERVICE CLAIM PROCEDURE

FILING A CLAIM

1. Claims should be submitted to the address shown on the ID card.

   The date of receipt will be the date the claim is received by the ***claims processor***.

2. All claims submitted for benefits must contain all of the following:

   a. Name of patient.
   b. Patient's date of birth.
   c. Name of ***employee***.
   d. Address of ***employee***.
   e. Name of ***employer*** and group number.
   f. Name, address and tax identification number of provider.
   g. ***Employee*** Blue Cross Blue Shield of Illinois Member Identification Number.
   h. Date of service.
   i. Diagnosis and diagnosis code.
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the ***accident***, ***injury*** or ***illness*** being treated.

   Cash register receipts, credit card copies, labels from containers and cancelled checks are not acceptable.

3. All claims not submitted within twelve (12) months from the date the services were rendered will not be a ***covered expense*** and will be denied.

The ***covered person*** may ask the health care provider to submit the claim directly to the ***claims processor*** or to the ***Preferred Provider Organization*** as outlined above, or the ***covered person*** may submit the bill with a claim form. However, it is ultimately the ***covered person's*** responsibility to make sure the claim for benefits has been filed.

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***covered person*** may provide the ***plan administrator*** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to the release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resources Department.

NOTICE OF CLAIM

A claim for benefits should be submitted to the ***claims processor*** within ninety (90) calendar days after the occurrence or commencement of any services by the ***Plan***, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than twelve (12) months after the loss occurs or commences unless the claimant is legally incapacitated.

Notice given by or on behalf of a ***covered person*** or the ***covered person's*** beneficiary, if any, to the ***plan administrator*** or to any authorized agent of the ***Plan***, with information sufficient to identify the ***covered person***, shall be deemed notice of claim.

TIME FRAME FOR BENEFIT DETERMINATION

After a completed claim has been submitted to the ***claims processor***, and no additional information is required, the ***claims processor*** will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the ***Plan's*** control.

After a completed claim has been submitted to the ***claims processor***, and if additional information is needed for determination of the claim, the ***claims processor*** will provide the ***covered person*** (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the ***Plan*** expects to make a decision. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***Plan*** will complete its determination of the claim within fifteen (15) calendar days of receipt by the ***claims processor*** of the requested information. Failure to respond in a timely and complete manner will result in an ***adverse benefit determination***.

NOTICE OF ADVERSE BENEFIT DETERMINATION

If the claim for benefits is denied, the ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written Notice of Adverse Benefit Determination within the time frames described immediately above.

The Notice of Adverse Benefit Determination shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.

2. The specific reasons for the ***adverse benefit determination***, to include:

    a. The denial code and its specific meaning, and
    b. A description of the ***Plan's*** standards, if any, used when denying the claim.

3. Reference to the ***Plan*** provisions on which the ***adverse benefit determination*** is based.

4. A description of any additional material or information needed and an explanation of why such material or information is necessary.

5. A description of the ***Plan's*** claim appeal procedure and applicable time limits.

6. A statement that if the ***covered person's*** appeal (Refer to *Appealing an Adverse Benefit Determination on a Post-Service Claim* below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Adverse Benefit Determination will contain either:

    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

8. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:

    a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

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APPEALING AN ADVERSE BENEFIT DETERMINATION ON A POST-SERVICE CLAIM

The "***named fiduciary***" for purposes of an appeal of an ***adverse benefit determination*** on a Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor***.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of an ***adverse benefit determination*** on a Post-Service claim by making written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the ***adverse benefit determination*** and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person*** for a full and fair review:

1. The ***covered person*** has the right to submit documents, information and comments and to present evidence and testimony.

2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

3. Before a final ***adverse benefit determination*** on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of ***final internal adverse benefit determination***. However there could be circumstances where the new or additional evidence or rationale could be received so late that it would be impossible to provide to the ***covered person*** in time to have a reasonable opportunity to respond. In these circumstances, the period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:

    a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
    b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.

4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

5. The review by the ***named fiduciary*** will not afford deference to the original ***adverse benefit determination***.

6. The ***named fiduciary*** will not be:

    a. The individual who originally denied the claim, nor
    b. Subordinate to the individual who originally denied the claim.

7. If the original ***adverse benefit determination*** was, in whole or in part, based on medical judgment:

    a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
    b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:

        (i.) An individual who was consulted in connection with the original ***adverse benefit determination***, nor
        (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original ***adverse benefit determination***.

8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original ***adverse benefit determination***, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON APPEAL

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the ***adverse benefit determination***.
2. Reference to specific ***Plan*** provisions on which the ***adverse benefit determination*** is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.
5. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for submitting the claim form, provider invoice and any documentation required to process the claim in the English language to the ***claims processor*** before payment of any benefits due are payable.

PRE-SERVICE CLAIM PROCEDURE

CARE COORDINATION PROCESS

INTRODUCTION

The ***Plan*** incorporates a "Care Coordination" process by Quantum Health which leverages resources including but not limited to your employer, the ***Plan*** and the ***claim administrator***, your provider and your community to help you best navigate the healthcare system. This process includes a staff of Care Coordinators who receive notifications regarding most healthcare services sought by ***covered persons***, and coordinate activities and information flow between the providers.

Care Coordination is intended to help ***covered persons*** obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and ensure early identification of ***covered persons*** with complex medical conditions. The Care Coordinators are available to ***covered persons*** and their providers for information, assistance, and guidance, and can be reached toll-free by calling:

Care Coordinators: 1 (844)460-2803

It is important to note that clinical reviews are done to determine *Plan* coverage and are conducted by the clinical staff of Quantum Health.

CARE COORDINATION REQUIREMENTS

In order to receive the highest benefits available in the ***Plan***, ***covered persons*** must follow the Care Coordination process outlined in this section, as well as other provisions in the ***Plan***. In some cases, failure to follow this process can result in significant benefit reductions, penalties or even loss of benefits for specific services.

The Care Coordination process generally includes:

- Use of in-network ***preferred providers***
- Designating a Coordinating ***Primary Care Provider*** (***PCP***)
- The Care Coordination Process and Utilization Management
    - Preauthorization and Clinical Review
    - Concurrent Utilization Review
    - Personal Care Guide Management

Use of In-Network *Preferred Providers*

The ***Plan*** offers a broad network of providers and provides the highest level of benefits when ***covered persons*** utilize "In-Network" ***preferred providers***. These networks will be indicated on your ***Plan*** identification card. **Services provided by Out-of-Network *nonpreferred providers* will not be eligible for the highest benefits**. Specific benefit levels are shown in the Schedule of Benefits.

Designated Coordinating Provider

All ***covered persons*** are asked to designate a coordinating (***PCP***) for each ***covered person*** in their family. While such designation is not mandatory, it is strongly recommended. **To ensure highest level of benefits, and the best coordination of your care, all *covered persons* are encouraged to designate an In-Network *PCP* to be their coordinating provider.** The Care Coordination process generally begins with the coordinating provider who maintains a relationship with the ***covered person***, provides general healthcare evaluation, guidance, and management.

Covered persons are encouraged to begin all healthcare events or inquiries with a call or visit to their designated ***PCP*** who will guide the ***covered person*** as appropriate. In addition to providing Care Coordination and submitting preauthorization requests, the ***PCP*** may also receive notices regarding healthcare services that their designated patients receive under the ***Plan***. This allows the ***PCP*** to provide ongoing healthcare guidance.

If you have trouble obtaining access to a ***PCP***, the Care Coordinators will be able to assist you by providing a list of ***preferred providers PCP's***. Please contact the Care Coordinators by calling:

Care Coordinators: 1 (844) 460-2803

Utilization Management

Preauthorization and Clinical Review

To be covered at the highest level of benefit and to ensure complete Care Coordination, the ***Plan*** requires that certain care, services, and procedures be preauthorized before they are provided. Preauthorization requests are submitted to the Care Coordinators by a designated ***PCP***, other ***PCP***, specialty provider or other healthcare provider. Your ***Plan*** identification card includes instructions and the phone number for them to call. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the request for the preauthorization and to ensure that the care, service and/or procedure meet ***Plan*** and nationally accepted medical

criteria. If a preauthorization request does not meet ***Plan*** and nationally accepted medical criteria, the ***covered person*** and healthcare provider will be notified, and the Care Coordinators will assist in redirecting care if appropriate.
The following care, services and procedures are subject to preauthorization:

The following services require pre-certification:

- ***Inpatient*** and Skilled Nursing ***Facility*** Admissions
- ***Outpatient*** Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy, radiation therapy, clinical trials)
- Genetic Testing
- Dialysis
- Organ, Tissue, and Bone Marrow Transplants
- ***Home Health Care***
- ***Hospice*** Care
- ***Durable Medical Equipment*** - all rentals and any purchase over $1500.
- ***Partial Confinement*** and Intensive ***Outpatient*** for ***Mental Health***/***Substance Use Disorders***

All preauthorization's and clinical review services are conducted by Quantum Health. Care Coordinators will assist ***covered persons*** in understanding what services require preauthorization.

For preauthorization, providers should call the number listed on the *Plan* identification card.

Concurrent Utilization Review

Quantum Health will regularly monitor an ***inpatient hospital*** stay, other institutional admission, or ongoing course of care for any ***covered person***, and evaluate the appropriateness of the level of care and determine if the stay is meeting ***medical necessity***. If necessary, they will examine the possible use of alternate levels of care or facilities. Quantum Health will communicate regularly with attending providers, the utilization management staff and/or discharge planners of such facilities, and the ***covered person*** and/or family to monitor the ***covered person's*** progress and anticipate and initiate planning for discharge needs. Such concurrent review, and authorization for ***Plan*** coverage of ***inpatient*** days, is conducted in accordance with the utilization criteria adopted by the ***Plan***, Quantum Health, and nationally accepted medical criteria.

Personal Care Guide Management

Quantum Health utilizes a primary nurse model for chronic condition as well as acute condition management. This enhanced approach provides one nurse to address clinical needs for all chronic and acute issues. The Personal Care Guide (PCG) nurse will consult with the ***covered person***, their family (if requested), the attending ***physician***, and other members of the ***covered person's*** treatment team to assist in facilitating/implementing proactive plans of care which provide the most appropriate health care and services in a timely, efficient and cost-effective manner. They assist with benefits, incidental health care issues, becoming healthier, finding resources or an unexpected healthcare journey.

During outreach, the Personal Care Guide will touch on the ***covered person's*** treatment and perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or in-network ***preferred providers***, as well as focus on the physical and emotional needs of the ***covered person***.

The Personal Care Guide will evaluate the ***covered person's*** psychosocial needs and social determinants of health. In addition to the depression screening, they will evaluate the ***covered person's*** financial situation, knowledge deficits, as well as any cultural barriers that may exist. Conversations with the ***covered person*** would occur at least monthly, if not more frequently, and continue until the ***covered person's*** health goals and needs are met.

The primary Personal Care Guide nurse will align with the ***covered person*** and be the single point of contact them, and their family and caregivers, and providers.

The primary Personal Care Guide nurse will:

- Provide comprehensive benefit education/utilization support
- Drive ***PCP*** designation and steerage to in-network ***preferred providers***
- Encourage provider involvement
- Deliver pre-certification assistance
- Perform pre-admission, pre-discharge, and post-discharge engagement
- Coordinate for utilization review and discharge planning
- Identify gaps in care and alleviate clinical, financial, and humanistic barriers
- Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
- Perform behavioral health screening
- Our primary nurse model has three foundational drivers for the changes:
    - Humanistic: to help members with acute and chronic needs by assigning a single nurse to the ***covered person*** and their family as well as a heightened attention to psychosocial issues that can negatively affect health, quality of life and financial outcomes.
    - Clinical: identify and prioritize members in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic conditions.
    - Financial: identify and outreach to members at risk for future high costs while encouraging preventive care and chronic condition management to improve health and reduce costs.

GENERAL PROVISIONS FOR CARE COORDINATION

Authorized Representative

The ***covered person*** is ultimately responsible for ensuring that all preauthorization's are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual preauthorization process will be executed by the ***covered person's PCP*** or other providers. By subscribing to this ***Plan***, the ***covered person*** authorizes the ***Plan*** and its designated service providers (including Quantum Health and the ***claim administrator***, and others) to accept healthcare providers or those providers who otherwise have knowledge of the ***covered person's*** medical condition, as their authorized representative in matters of Care Coordination, including preauthorization requests. Communications with and notifications to such healthcare providers shall be considered as notification to the ***covered person***.

Time of Notice

The preauthorization request should be made to the Care Coordinators within the following timeframe:

- At least **three (3) business days,** before a scheduled (elective) ***inpatient*** admission
- By the next business day after, an emergency ***Hospital*** admission
- Upon being identified as a potential organ or tissue transplant recipient
- At least **three (3) business days** before receiving any other services requiring preauthorization

For preauthorization, providers should call the number listed on the *Plan* identification card.

Special Note: The *covered person* will not be penalized for failure to obtain preauthorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, ***covered persons*** who receive care on this basis must contact the Care Coordinators as soon as possible within twenty-four (24) hours of the first business day after receiving care or ***hospital*** admittance. Care Coordinators will then coordinate with Quantum Health Utilization Management to review services provided within forty-eight (48) hours of being contacted.

"Emergency" Admissions and procedures

Any ***inpatient*** admission or ***outpatient*** procedure that has not been previously scheduled and cannot be delayed without harming the covered ***person's*** health is considered an emergency for purposes of the Utilization Management notification.

Maternity Admissions

A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably thirty (30) days prior to expected delivery. The ***Plan*** and the Care Coordination process complies with all state and federal regulations regarding Utilization Management for maternity admissions. The ***Plan*** will not restrict benefits for any ***hospital*** stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require preauthorization or authorization for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable forty-eight (48) or ninety-six (96) hours, the ***Plan*** will only consider benefits for the actual length of the stay. The ***Plan*** will not set benefit levels or out-of-pocket costs so that any later portion of the forty-eight (48) or ninety-six (96)-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Care Coordination is Not a Guarantee of Payment of Benefits

The Care Coordination process does not provide a guarantee of payment of benefits. Approvals of preauthorization's for procedures, hospitalizations and other services indicate that the medical condition, services, and care settings meet the utilization criteria established by the ***Plan***. The Care Coordination approvals do not indicate that the service is a covered benefit, that the covered ***person*** is eligible for such benefits, or that other benefit conditions such as ***copay***, deductible, ***coinsurance***, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the ***Plan***.

Appeal of Care Coordination Determinations

Covered persons have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of benefits and penalties. The appeal process is detailed in the Claims and Appeal Procedures section within this document.

NOTICE OF ADVERSE BENEFIT DETERMINATION ON A PRE-SERVICE CLAIM

If a pre-certification request is denied in whole or in part, the ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written Notice of an Adverse Benefit Determination on a Pre-Service Claim within the time frames above.

The Notice of Adverse Benefit Determination on a Pre-Service Claim shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.

2. The specific reasons for the denial, to include:

a. The denial code and its specific meaning, and
b. A description of the ***Plan's*** standards, if any, used when denying the claim.

3. Reference to the ***Plan*** provisions on which the ***adverse benefit determination*** is based.

4. A description of any additional material or information needed and an explanation of why such material or information is necessary.

5. A description of the ***Plan's*** claim appeal procedure and applicable time limits.

6. A statement that if the ***covered person's*** appeal (Refer to *Appealing an Adverse Benefit Determination on a Pre-Service Claim* below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Adverse Benefit Determination on a Pre-Service Claim will contain either:

   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

8. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING AN ADVERSE BENEFIT DETERMINATION OF A DENIED PRE-SERVICE CLAIM

The "***named fiduciary***" for purposes of an appeal of an ***adverse benefit determination*** of a pre-service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), or the ***pharmacy benefit manager*** for prescription drug claims when prior authorization is required.

A ***covered person*** (or authorized representative) may request a review of an ***adverse benefit determination*** of a pre-service claim by making a verbal or written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the ***adverse benefit determination*** and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person*** for a full and fair review:

1. The ***covered person*** has the right to submit documents, information and comments and to present testimony.

2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the ***named fiduciary*** will not afford deference to the original ***adverse benefit determination***.

5. The ***named fiduciary*** will not be:

   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.

6. If the original ***adverse benefit determination*** was, in whole or in part, based on medical judgment:

a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:

(i.) An individual who was consulted in connection with the original ***adverse benefit determination***, nor
(ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original ***adverse benefit determination***.

7. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original ***adverse benefit determination***, whether or not the advice was relied upon.

NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal (not applicable to ***urgent care*** claims).

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the ***adverse benefit determination***.

2. Reference to specific ***Plan*** provisions on which the ***adverse benefit determination*** is based.

3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.

5. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:

a. A copy of that criterion, or
b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:

a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
b. A statement that such explanation will be supplied free of charge, upon request.

CASE MANAGEMENT

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the ***Health Care Management Organization*** may arrange for review and/or case management services from a professional qualified to perform such services. The ***plan administrator*** shall have the right to alter or waive the normal provisions of the ***Plan*** when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

In addition, the ***Health Care Management Organization*** may recommend (or change) alternative:

- methods of medical care or treatment;
- equipment; or
- supplies;

that differ from the medical care or treatment, equipment or supplies that are considered ***covered expenses*** under the ***Plan***.

The recommended alternatives will be considered as ***covered expenses*** under the ***Plan*** provided the expenses can be shown to be viable, ***medically necessary***, and are included in a written case management report or treatment plan proposed by the ***Health Care Management Organization***.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person***.

POST-SERVICE AND PRE-SERVICE CLAIM EXTERNAL APPEALS PROCEDURE

EXTERNAL APPEAL

The "***named fiduciary***" for purposes of an external appeal of an ***adverse benefit determination*** on a Pre-Service or Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1, is the ***claims processor***.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of an ***adverse benefit determination*** appeal if the claim determination involves medical judgment; whether items or services are subject to the requirements specified in numbers 1. through 6. in the subsection *Nonpreferred Provider*, under the section, *Preferred Provider or Nonpreferred Provider*; or a rescission. Medical judgment includes, but is not limited to:

1. ***Medical necessity***;

2. Appropriateness;

3. ***Experimental*** or ***investigational*** treatment;

4. Health care setting;

5. Level of care; and

6. Effectiveness of a ***covered expense***.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of ***final internal adverse benefit determination***. {*Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.*}

RIGHT TO EXTERNAL APPEAL

Within five (5) business days of receipt of the request, the ***claims processor*** will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the ***final internal adverse benefit determination*** was the result of:

1. Medical judgment;

2. Whether items or services are subject to the requirements specified in numbers 1. through 6. in the *Nonpreferred Provider* subsection, under the *Preferred Provider or Nonpreferred Provider* section; or

3. Rescission of coverage under this ***Plan***.

NOTICE OF RIGHT TO EXTERNAL APPEAL

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 1-866-444-3272, if the request is complete but not eligible for external review.

2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the ***covered person*** to perfect the external review request by the later of the following:

    a. The four (4) month filing period; or
    b. Within the forty-eight (48) hour time period following the ***covered person's*** receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the ***covered person*** in writing of the request's eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

The assigned IRO shall provide the ***plan administrator*** (or its designee) and the ***covered person*** (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the ***covered person***, the ***Plan*** and ***claims processor***, except to the extent that other remedies may be available under State or Federal law.

EXPEDITED EXTERNAL REVIEW

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) the right to request an expedited external review upon the ***covered person's*** receipt of either of the following:

1. An ***adverse benefit determination*** involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function and the ***covered person*** has filed an internal appeal request.

2. A ***final internal adverse benefit determination*** involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function or if the ***final internal adverse benefit determination*** involves any of the following:

    a. An admission,
    b. Availability of care,
    c. Continued stay, or
    d. A health care item or service for which the ***covered person*** received ***emergency services***, but has not yet been discharged from a ***facility***.

Immediately upon receipt of the request for *Expedited External Review*, the ***Plan*** will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, *Right to External Appeal*.

2. Send notice of the ***Plan's*** decision, as described in the subsection, *Notice of Right to External Appeal*.

Upon determination that a request is eligible for external review, the ***Plan*** will do all of the following:

1. Assign an IRO as described in the subsection, *Independent Review Organization*.

2. Provide all necessary documents or information used to make the ***adverse benefit determination*** or final ***adverse benefit determination*** to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the ***covered person's*** medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the ***plan administrator*** (or its designee) and the ***covered person*** (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

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COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed one hundred percent (100%) of "allowable expenses." Only the amount paid by this ***Plan*** will be charged against the ***Essential Health Benefits***/non-***Essential Health Benefits maximum benefit***.

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses ***incurred*** while covered under this ***Plan***, part or all of which would be covered under this ***Plan***. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this ***Plan***.

When this ***Plan*** is secondary, "Allowable Expense" will include any deductible or ***coinsurance*** amounts not paid by the Other Plan(s).

This ***Plan*** is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this ***Plan*** shall be secondary only.

When this ***Plan*** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies. "Other Plan" also does not include Tricare, ***Medicare***, Medicaid or a state child health insurance program (CHIP). Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, ***hospital*** indemnity benefits and ***hospital*** reimbursement-type plans;

2. ***Hospital*** or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;

10. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

"This ***Plan***" shall mean that portion of the ***employer's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the ***covered person*** for whom a claim is made has been covered under this ***Plan***.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expenses.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan***.

ORDER OF BENEFIT DETERMINATION

Except as provided below in *Coordination with Medicare*, each plan will make its claim payment according to the first applicable provision in the following list of provisions which determine the order of benefit payment:

1. No Coordination of Benefits Provision

   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent

   The plan which covers the claimant directly pays before a plan that covers the claimant as a dependent.

3. Dependent Children of Parents not Separated or Divorced

   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents

   When parents are separated or divorced, the birthday rule does not apply, instead:

   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

5. Active/Inactive

   The plan covering a person as an active (not laid off or retired) employee or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.

6. Longer/Shorter Length of Coverage

If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

COORDINATION WITH MEDICARE

Individuals may be eligible for ***Medicare*** Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in ***Medicare*** Part B and D is available to all individuals who make application and pay the full cost of the coverage.

1. When an ***employee*** becomes entitled to ***Medicare*** coverage (due to age or disability) and is still actively at work, the ***employee*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage (due to age or disability) and the ***employee*** is still actively at work, the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***employee*** and/or ***dependent*** are also enrolled in ***Medicare*** (due to age or disability), this ***Plan*** shall pay as the primary plan. If, however, the ***Medicare*** enrollment is due to end stage renal disease, the ***Plan's*** primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in ***Medicare*** law and regulations. If the ***employee*** and/or ***dependent*** does not elect ***Medicare***, but is otherwise eligible due to end stage renal disease, benefits will be paid as if ***Medicare*** has been elected and this ***Plan*** will pay secondary benefits upon completion of the thirty (30) month "coordination period."

4. Notwithstanding Paragraphs 1 to 3 above, if the ***employer*** (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) ***employees***, when a covered ***dependent*** becomes entitled to ***Medicare*** coverage due to ***total disability***, as determined by the Social Security Administration, and the ***employee*** is actively-at-work, ***Medicare*** will pay as the primary payer for claims of the ***dependent*** and this ***Plan*** will pay secondary.

5. If the ***employee*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan***. ***Medicare*** will be the only payor.

This section is subject to the terms of the ***Medicare*** laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***Essential Health Benefits***/non-***Essential Health Benefits maximum benefit*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***employer*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any ***covered person***. Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

AUTOMOBILE ACCIDENT BENEFITS

The ***Plan's*** liability for expenses arising out of an automobile accident shall always be secondary to any automobile insurance, irrespective of the type of automobile insurance law that is in effect in the ***covered person's*** state of residence. Currently, there are three (3) types of state automobile insurance laws.

1. No-fault automobile insurance laws

2. Financial responsibility laws

3. Other automobile liability insurance laws

No Fault Automobile Insurance Laws. In no event will the ***Plan*** pay any claim presented by or on behalf of a ***covered person*** for medical benefits that would have been payable under an automobile insurance policy but for an election made by the principal named insured under the automobile policy that reduced covered levels and/or subsequent premium. This is intended to exclude, as a ***covered expense***, a ***covered person's*** medical expenses arising from an automobile accident that are payable under an automobile insurance policy or that would have been payable under an automobile insurance policy but for such an election.

1. In the event a ***covered person*** incurs medical expenses as a result of ***injuries*** sustained in an automobile accident while "covered by an automobile insurance policy," as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance; provided however that benefits payable due to a required deductible under the automobile insurance policy will be paid by the ***Plan*** up to the amount equal to that deductible.

2. For the purposes of this section the following people are deemed "covered by an automobile insurance policy."

    a. An owner or principal named insured individual under such policy.
    b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
    c. Any other person who, except for the existence of the ***Plan***, would be eligible for medical expense benefits under an automobile insurance policy.

Financial Responsibility Laws. The ***Plan*** will be secondary to any potentially applicable automobile insurance even if the state's "financial responsibility law" does not allow the ***Plan*** to be secondary.

Other Automobile Liability Insurance. If the state does not have a no-fault automobile insurance law or a "financial responsibility" law, the ***Plan*** is secondary to automobile insurance coverage or to any other person or entity who caused the ***accident*** or who may be liable for the ***covered person's*** medical expenses pursuant to the general rule for *Subrogation/Reimbursement*.

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SUBROGATION/REIMBURSEMENT

The ***Plan*** is designed to only pay ***covered expenses*** for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a ***covered person*** in a time of need, however, the ***Plan*** may pay ***covered expenses*** that may be or become the responsibility of another person, provided that the ***Plan*** later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the ***Plan***, as well as by applying for payment of ***covered expenses***, a ***covered person*** is subject to, and agrees to, the following terms and conditions with respect to the amount of ***covered expenses*** paid by the ***Plan***:

1. Assignment of Rights (Subrogation). The ***covered person*** automatically assigns to the ***Plan*** any rights the ***covered person*** may have to recover all or part of the same ***covered expenses*** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the ***Plan***. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a ***covered person*** or paid to another for the benefit of the ***covered person***. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the ***covered person*** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the ***Plan*** to pursue any claim that the ***covered person*** may have, whether or not the ***covered person*** chooses to pursue that claim. By this assignment, the ***Plan's*** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The ***Plan*** shall have an equitable lien against any rights the ***covered person*** may have to recover the same ***covered expenses*** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the ***Plan***. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid ***covered expenses*** prior to a determination that the ***covered expenses*** arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the ***covered person***, the ***covered person's*** attorney, and/or a trust) as a result of an exercise of the ***covered person's*** rights of recovery (sometimes referred to as "proceeds"). The ***Plan*** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the ***plan administrator***, the ***Plan*** may reduce any future ***covered expenses*** otherwise available to the ***covered person*** under the ***Plan*** by an amount up to the total amount of Reimbursable Payments made by the ***Plan*** that is subject to the equitable lien.

   This and any other provisions of the ***Plan*** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the ***Plan*** concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in ***Plan's*** Reimbursement Activities. The ***covered person*** has an obligation to assist the ***Plan*** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the ***covered person***, and to provide the ***Plan*** with any information concerning the ***covered person's*** other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the ***covered person***. The ***covered person*** is required to (a) cooperate fully in the ***Plan's*** (or any ***Plan*** fiduciary's) enforcement of the terms of the ***Plan***, including the exercise of the ***Plan's*** right to subrogation and reimbursement, whether against the ***covered person*** or any third party, (b) not do anything to prejudice those

enforcement efforts or rights (such as settling a claim against another party without including the ***Plan*** as a co-payee for the amount of the Reimbursable Payments and notifying the ***Plan***), (c) sign any document deemed by the ***plan administrator*** to be relevant to protecting the ***Plan's*** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the ***plan administrator*** or ***claims processor*** to enforce the ***Plan***'s rights.

The ***plan administrator*** has delegated to the ***claims processor*** for medical claims the right to perform ministerial functions required to assert the ***Plan's*** rights with regard to such claims and benefits; however, the ***plan administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

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GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered by Benefits Committee, or other entity or individual designated by the Benefits Committee to supervise the administration of the ***Plan***. The ***plan administrator*** shall have full charge of the operation and management of the ***Plan***. The ***plan administrator*** has retained the services of an independent ***claims processor*** experienced in claims review.

The ***plan administrator*** is the ***named fiduciary*** of the ***Plan*** except as noted herein. Except as otherwise specifically provided in this document, the ***claims processor*** is the ***named fiduciary*** of the ***Plan*** for determining pre-service and post-service claim appeals. As the ***named fiduciary*** for appeals, the ***claims processor*** and any other party who is the ***named fiduciary*** determining appeals maintains discretionary authority to review all denied claims under appeal for benefits under the ***Plan***. The ***plan administrator*** maintains discretionary authority to interpret the terms of the ***Plan***, including but not limited to, determination of eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan***. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

APPLICABLE LAW

All provisions of the ***Plan*** shall be construed and administered in a manner consistent with the requirements under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

ASSIGNMENT

Coverage and the ***covered person's*** rights under this ***Plan*** may not be assigned. A direction to pay a provider is not an assignment of any right under this ***Plan*** or of any legal or equitable right to institute any court proceeding.

Payment of Benefits

Benefits will be processed as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. All covered health benefits are payable to the ***covered person***. However, the ***Plan*** has the right to pay any health benefits to the service provider. This will be done unless the ***covered person*** has told the ***claims processor*** otherwise by the time the ***covered person*** files the claim and a reasonable amount of time for the ***claims processor*** to process the ***covered person's*** request.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatments have been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate***, after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider***.

The ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

Additional Provisions

The ***Plan's***, ***Plan Sponsor's***, ***plan administrator's, claim processor's*** failure to implement or insist upon compliance with any provision of this ***Plan*** at any given time or times, shall not constitute a waiver of the right to implement or insist upon compliance with that provision at any other time or times.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under the ***Plan***. Such right to benefits is not transferable.

CLAIM EDITS

Claim edits derived from nationally recognized standards, including but not limited to: CPT, HCPCS, ICD-10 and modifiers, may be applied to ***covered expenses*** to ensure appropriate valid code relationships and to identify bundling and unbundling scenarios. As a result, ***covered expenses*** may be reduced.

CLERICAL ERROR

No clerical error on the part of the ***employer*** or ***claims processor*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***employee*** or any ***dependent(s)*** hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** which is in conflict with statutes which are applicable to the ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The ***effective date*** of this Medical Benefit Booklet is January 1, 2024.

FRAUD OR INTENTIONAL MISREPRESENTATION

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan***, or otherwise misleads the ***Plan***, the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person***, or from any other person responsible for misleading the ***Plan***, and from the person for whom the benefits were provided. Any fraud or intentional misrepresentation of a material fact on the part of the ***covered person*** or an individual seeking coverage on behalf of the individual in making application for coverage, or any application for reclassification thereof, or for service thereunder is prohibited and shall render the coverage under the ***Plan*** null and void.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in the ***Plan*** shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a ***hospital*** or to make a free choice of the attending ***physician*** or ***professional provider***. However, benefits will be paid in accordance with the provisions of the ***Plan***, and the ***covered person*** may have higher out-of-pocket expenses if the ***covered person*** uses the services of a ***nonpreferred provider***.

INCAPACITY

If, in the opinion of the ***employer***, a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due the ***covered person*** and in the absence of written evidence to the ***Plan*** of the qualification of a guardian or personal representative for the ***covered person's*** estate, the ***employer*** may on behalf of the ***Plan***, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the ***Plan's*** obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the ***employer*** or by the ***employee*** covered under the ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under the ***Plan*** or be used in defense to a claim

unless they are contained in writing and signed by the ***employer*** or by the ***covered person***, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

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 the ***Plan***, (b) any medical history which might be pertinent to such illness, injury, claim or claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such claim or claims, furnish to the ***claim administrator*** or its agent, and agree that any such provider, person or other entity may furnish to the ***claim administrator*** or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, claim or claims. In addition, the ***claim administrator*** may furnish similar information and records (or copies of records) to providers, 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 the ***claim administrator*** and/or your ***employer*** or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the ***claim administrator*** be able to make claim payments in accordance with MSP laws.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the ***Plan*** as described herein, prior to the expiration of sixty (60) days after a claim has been furnished to the ***claim administrator*** in accordance with the requirements described in this ***Plan***. In addition, no such action shall be brought after the expiration of three (3) years after the time a claim is required to be furnished to the ***claim administrator*** in accordance with the requirements described in this ***Plan***.

LEGAL ACTIONS

The decision by the ***plan administrator/claims processor*** on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. All claim review procedures provided for in this ***Plan*** Document must be exhausted before any legal or equitable action is brought. Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the ***Plan***, ***plan administrator/claims processor***, any other fiduciary, or their employees, must be filed within one (1) year from the date all claim review procedures provided for in this ***Plan*** Document have been exhausted.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the ***employer*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The ***employer*** shall not be liable for the negligence, wrongful act, or omission of any ***physician***, ***professional provider***, ***hospital***, or other institution, or their employees, or any other person. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the ***plan administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in the applicable Claim Filing Procedure section of this document.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a state Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a state Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any state law which provides that the state has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan***.

NOTICES

Any information or notice which you furnish to the ***claim administrator*** under the ***Plan*** as described herein must be in writing and sent to Blue Cross and Blue Shield of Illinois at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this ***Plan*** for a specific situation). Any information or notice which the ***claim administrator*** furnishes to you must be in writing and sent to you at your address as it appears on the ***claim administrator***'s records or in care of your ***employer*** and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the ***claim administrator***'s records. The ***claim administrator*** may also provide such notices electronically to the extent permitted by applicable law.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan***, at its own expense, shall have the right to require an examination of a person covered under the ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The ***Plan*** shall not be deemed to constitute a contract between the ***employer*** and any ***employee*** or to be a consideration for, or an inducement or condition of, the employment of any ***employee***. Nothing in the ***Plan*** shall be deemed to give any ***employee*** the right to be retained in the service of the ***employer*** or to interfere with the right of the ***employer*** to terminate the employment of any ***employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***employer*** or its delegate may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons***. Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan***, the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer***, or a written copy thereof shall be deposited with such master copy of the ***Plan***. Appropriate filing and reporting of any such modification or amendment with governmental authorities, if applicable, and to ***covered persons*** shall be timely made by the ***employer***.

PLAN TERMINATION

The ***employer*** reserves the right to terminate the ***Plan*** at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons***.

PRIOR PLAN COVERAGE

Employees and ***dependents*** who are covered under the ***employer's prior plan*** as of the day immediately prior to the ***effective date*** of this ***Plan*** shall be covered hereunder, provided they have elected coverage under this ***Plan***. ***Employees*** who have not satisfied the ***prior plan's*** waiting period shall become effective under this ***Plan*** upon completing the waiting period of the ***prior plan***.

PRONOUNS

All personal pronouns used in the ***Plan*** shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

If this ***Plan*** pays benefits for ***covered expenses*** incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), this ***Plan*** or the ***claim administrator*** has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to ***preferred providers*** or ***nonpreferred providers.***

If no refund is received, this ***Plan*** and/or ***claim administrator*** (either in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this ***Plan,*** whether for the same or a different member; or
b. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program; or
c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or
d. Any future benefit payment, or other payment, made to any person or entity; or
e. Any future benefit payment owed to one or more ***preferred providers*** or ***nonpreferred providers.***

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

SEVERABILITY

Should any part of this ***Plan*** subsequently be invalidated by a court of competent jurisdiction, the remainder of the ***Plan*** shall be given effect to the maximum extent possible.

STATUS CHANGE

If an ***employee*** or ***dependent*** has a status change while covered under this ***Plan*** (*i.e.*, ***dependent*** to ***employee***, COBRA to active) and no interruption in coverage has occurred, the ***Plan*** will provide continuous coverage with respect to any deductible(s), ***coinsurance*** and ***Essential Health Benefits/***non-***Essential Health Benefits maximum benefit***.

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:01 a.m. as may be legally in effect at the address of the ***plan administrator***.

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

BlueCross BlueShield of Illinois

LSC Communications LLC
"Privacy Officer"
4101 Winfield Road
Warrenville, IL 60555
www.Lsccom.com

NOTICE OF PRIVACY PRACTICES
Effective Date of this Notice: Same as the effective date on the cover page of this Plan

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

BlueCross BlueShield of Illinois

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

BlueCross BlueShield of Illinois

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

BlueCross BlueShield of Illinois

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Accident

An unforeseen event resulting in ***injury***.

Adverse Benefit Determination

Adverse benefit determination shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. 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 or make payment that is based on a determination of a ***covered person's*** eligibility to participate in the ***Plan***.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be ***experimental/investigational*** or not ***medically necessary*** or appropriate.

Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 and all applicable regulations and regulatory guidance.

Air Mileage Rate

A ***contracted rate*** expressed in dollars per loaded mile (statute miles not nautical miles) flown.

Alternate Recipient

Any child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under the ***Plan***.

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by ***Medicare***; or that has a contract with the ***Preferred Provider Organization*** as a ***preferred provider***. An ***ambulatory surgical facility*** is a ***facility*** that:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;

2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility***;

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a ***facility*** used as an office or clinic for the private practice of a ***physician***.

Anesthesia Conversion Factor

A ***median contracted rate*** expressed in dollars per unit.

Applied Behavioral Analysis (ABA)

A type of intensive behavioral therapy in which individuals trained in objective observation, evidence-based assessment, data collection, and functional analyses utilize these data to produce meaningful changes in human behavior.

Approved Clinical Trial

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 further described in accordance with federal law and applicable federal regulations.

Autism Spectrum Disorder

A condition related to brain development that affects how a person perceives and socializes with others, causing problems in social interaction and communication. This disorder also includes limited and repetitive behavior.

Base Unit

For an anesthesia service code, ***base units*** are specified in the most recent edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide.

Birthing Center

A ***facility*** that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

Certified IDR Entity

An entity responsible for conducting payment determinations, through the Federal independent dispute resolution process, that has been certified by the Secretaries of Labor, Health and Human Services and the Treasury.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

Refer to the *Summary Plan Description* (SPD) section of this document.

Close Relative

The ***employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee's*** spouse.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan***. The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy***, but is adversely affected by or caused by ***pregnancy***. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic ***pregnancy***.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician***; morning sickness; or like conditions that are not medically termed as ***complications of pregnancy***.

Concurrent Care

A request by a ***covered person*** (or their authorized representative) to the ***Health Care Management Organization*** prior to the expiration of a ***covered person's*** current course of treatment to extend such treatment OR a determination by the ***Health Care Management Organization*** to reduce or terminate an ongoing course of treatment.

Confinement

A continuous stay in a ***hospital***, ***treatment center***, ***extended care facility***, ***hospice***, or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician***..

Continuing Care Patient

A ***covered person*** who, with respect to a ***preferred provider*** is:

1. Undergoing a course of treatment for a ***serious and complex condition*** from the ***preferred provider***;
2. Undergoing a course of institutional or ***inpatient*** care from the ***preferred provider***;
3. Scheduled to undergo nonelective surgery from the ***preferred provider***, including postoperative care;
4. Pregnant and undergoing a course of treatment for the pregnancy from the ***preferred provider***; or
5. Determined to be terminally ill with a life expectancy of 6 months or less, and is receiving treatment for such ***illness*** from the ***preferred provider***.

Contracted Rate

The total amount (including ***cost sharing***) that plan sponsors of self-funded plans administered by ***claims processor*** are contractually agreed to pay a ***preferred provider*** for ***covered expenses***.

Copay

A cost sharing arrangement whereby a ***covered person*** pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Cost Sharing

The amount a ***covered person*** is responsible for paying for ***covered expenses***. ***Cost sharing*** includes applicable ***copays***, ***coinsurance*** and deductible. ***Cost sharing*** does not include balance billing by ***nonpreferred providers***, or the cost of items or services that are not ***covered expenses***.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician***, ***professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under the ***Plan***, or becomes eligible at a later date, and for whom the coverage provided by the ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury***. ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under the ***Plan***, and (2) if combined with other ***medically necessary*** therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount

The *customary and reasonable amount* will be (a) in the case of a health care provider, other than a *professional provider*, which does not have a written agreement with the *claim administrator* or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a *preferred provider* by any Blue Cross and/or Blue Shield Plan at the time covered services are rendered, the following amount:

(i) the lesser of (unless otherwise required by applicable law or arrangement with the *nonpreferred provider*) (a) the provider's billed charges, and (b) an amount determined by the *claim administrator* to be approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular covered service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the claim, the lesser of (unless otherwise required by applicable law or arrangement with the *nonpreferred provider*) (a) the provider's billed charges and (b) an amount determined by the *claim administrator* to be 150% of the *negotiated rate* that would apply if the services were rendered by a *preferred professional provider* on the date of service; or

(iii) if the base Medicare reimbursement amount and the *customary and reasonable amount* cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the claim, then the amount will be 50% of the provider's billed charges (unless otherwise required by applicable law or arrangement with the *nonpreferred provider*), provided, however, that the *claim administrator* may limit such amount to the lowest contracted rate that the *claim administrator* has with a *preferred provider* for the same or similar services based upon the type of provider and the information submitted on the claim, as of January 1 of the same year that the covered services are rendered to you.

The *claim administrator* will utilize the same claim processing rules, edits or methodologies that it utilizes in processing *preferred provider* claims for processing claims submitted by *nonpreferred providers* which may also alter the *customary and reasonable amount* for a particular service. In the event the *claim administrator* does not have any claim edits, rules or methodologies, the *claim administrator* may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The *customary and reasonable amount* will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the *customary and reasonable amount* does not equate to the *nonpreferred provider's* claim charge, you will be responsible for the difference between such amount and the claim charge, along with any applicable *copay*, *coinsurance* and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by the *claim administrator* within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The *customary and reasonable amount* will be (b) in the case of *nonpreferred professional providers*, the lesser of (unless otherwise required by applicable law or arrangement with *nonpreferred providers*):

(i) the provider's claim charge, or;
(ii) the *claim administrator's customary and reasonable amount*. Except as otherwise provided in this section, the *customary and reasonable amount* is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the claim. Notwithstanding the preceding sentence, (1) *the customary and reasonable amount* for home health care covered services will be 50% of the *nonpreferred professional provider's* standard claim charge for such covered services, (2) the *customary and reasonable amount* for ambulance services provided by providers (other than providers that bill through a *preferred provider*, which use a *negotiated rate*) will be such provider's billed charge, and (3) the *customary and reasonable amount* for other unsolicited providers will be the same as the *negotiated rate*.

When a Medicare reimbursement rate is not available for a covered service or is unable to be determined based on the information submitted on the claim, the *customary and reasonable amount* for *nonpreferred professional providers* will be 100% of the *claim administrator's* rate for such covered services according to its current schedule of maximum allowances. If there is no rate according to the schedule of maximum allowances, then the *customary and reasonable amount* will be 25% of claim charges.

The *claim administrator* will utilize the same claim processing rules, edits or methodologies that it utilizes in processing *preferred professional provider* claims for processing claims submitted by *nonpreferred professional providers* which may also alter the *customary and reasonable amount* for a particular covered service. In the event the *claim administrator* does not have any claim edits, rules or methodologies, the *claim administrator* may utilize the Medicare claim rules or edits that are used by Medicare in processing such claims. The *customary and reasonable amount* will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the *customary and reasonable amount* does not equate to the *nonpreferred professional provider's* claim charge, you will be responsible for the difference between such amount and the claim charge, along with any applicable *copay*, *coinsurance* and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by the *claim administrator* within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Covered expenses provided by a ***nonpreferred provider*** subject to the requirements specified in the *Nonpreferred Provider subsection*, under the *Preferred Provider or Nonpreferred Provider section*, are not subject to the ***customary and reasonable amount***, but instead are subject to the lesser of the ***qualifying payment amount*** or the ***nonpreferred provider's*** actual charge.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person***, who is practicing within the scope of that Doctor's license.

Dependent

Refer to the *Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility* section for what constitutes a ***dependent***.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Is generally not used in the absence of an ***illness*** or ***injury***;

4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment***. ***Durable medical equipment*** includes, but is not limited to: crutches, wheelchairs, ***hospital*** beds, etc.

Effective Date

The date of the ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Emergency Medical Condition

A medical condition, including a ***mental health disorder*** or ***substance use disorder***, manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 ***covered person's*** life (or with respect to a pregnant ***covered person***, the health of the ***covered person*** or the pregnant ***covered person's*** unborn child) in serious jeopardy, or

2. Causing serious impairment to bodily functions, or

3. Causing serious dysfunction of any bodily organ or part.

Emergency Services

1. With respect to an ***emergency*** medical condition, a medical screening examination that is within the capability of the emergency department of a ***hospital***, or of an ***independent freestanding emergency department***, including ancillary services routinely available to the emergency department to evaluate such ***emergency medical condition***, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at a ***hospital*** or an ***independent freestanding emergency department***, as are required to ***stabilize*** the patient; and

2. Additional items and services,

a. For which benefits are provided or covered under this ***Plan***; and

b. That are furnished by a ***nonpreferred provider*** (regardless of the department of the ***hospital*** or ***independent freestanding emergency department*** in which such items or services are furnished) after the ***covered person*** is ***stabilized*** and as part of ***outpatient*** observation or an ***inpatient*** or ***outpatient*** stay with respect to the visit in which the services provided by the emergency department are furnished; however, such items and services shall not be included as ***emergency services*** if:

   i. The attending ***physician*** or treating provider determines that the ***covered person*** is able to travel using nonmedical transportation or nonemergency medical transportation to an available ***preferred provider*** or ***facility*** located within a reasonable travel distance, taking into account the individual's medical condition;

   ii. Notice and Consent Criteria is satisfied, as specified in section, *Preferred Provider or Nonpreferred Provider*, under number 6. of subsection *Nonpreferred Provider*; and

   iii. The ***covered person*** (or an authorized representative) is in a condition to receive the notice and consent described in the Notice and Consent Criteria as determined by the attending emergency ***physician*** or treating provider using appropriate medical judgement, and to provide informed consent in accordance with applicable law.

Employee

A person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the ***employer***, who is regularly scheduled to work not less than the hours per work week as listed in the section titled *Eligibility, Enrollment and Effective Date, Employee Eligibility* on a ***full-time*** status basis.

Employer

The ***employer*** is LSC Communications LLC.

Essential Health Benefits

Those benefits identified by the U.S. Secretary of Health and Human Services, including benefits for ***covered expenses*** incurred for the following services:

1. Ambulatory patient services;
2. ***Emergency services***;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. ***Habilitative services***, ***rehabilitative services*** and ***habilitative and rehabilitative devices***;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management;
10. Pediatric services, including oral and vision care.

Experimental/Investigational

Services, supplies, drugs and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator***, or their designee must make an independent evaluation of the ***experimental***/non-experimental standings of specific technologies. The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have

also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** or their designee will be guided by the following examples of ***experimental*** services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, ***experimental***, study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury***, professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each ***covered person***.

5. It is not, other than incidentally, a place for rest, a place for the aged or a place for custodial or educational care.

6. It is approved and licensed by ***Medicare***.

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements.

Final Internal Adverse Benefit Determination

An ***adverse benefit determination*** that has been upheld by this ***Plan*** at the conclusion of the internal claim and appeal process, or an ***adverse benefit determination*** with respect to which the internal claim and appeal process has been deemed exhausted.

Foster Child

A child who is placed with the ***employee*** by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Full-time

Employees who are regularly scheduled to work not less than the hours per work week as listed in the section titled *Eligibility, Enrollment and Effective Date, Employee Eligibility*.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Habilitative and Rehabilitative Devices

Medically necessary devices that are designed to assist a ***covered person*** in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. Such devices include, but are not limited to, ***durable medical equipment***, orthotics, prosthetics, and low vision aids.

Habilitative Services

Medically necessary health care services that help a ***covered person*** keep, learn or improve skills and functioning for daily living. Examples of ***habilitative services*** include therapy for a ***dependent*** child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other ***medically necessary*** services for people with disabilities in a variety of inpatient and/or outpatient settings. ***Habilitative services*** that are not ***medically necessary***, for example when therapy has reached an end point and goals have been reached, will not be a ***covered expense***.

Health Care Management

A process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care.

Health Care Management Organization

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary***. The ***Health Care Management Organization*** may be contacted by calling the telephone number for pre-certification found on the ***covered person's*** ID card.

Home Health Aide Services

Services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care

Includes the following services: private duty nursing, skilled nursing visits, ***hospice*** and IV Infusion therapy for the purposes of pre-service claims only.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

3. It maintains a complete medical record on each ***covered person***.

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare***.

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a ***physician***.

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person***.

9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals***.

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury***; and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This condition may be waived in the case of treatment for an ***emergency medical condition*** in a ***hospital*** outside of the United States.

5. It must be approved by ***Medicare***. This condition may be waived in the case of treatment for an ***emergency medical condition*** in a ***hospital*** outside of the United States.

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for physical ***rehabilitative services*** where the ***covered person*** received treatment as a result of an ***illness*** or ***injury***.

The term ***hospital***, when used in conjunction with ***inpatient confinement*** for ***mental health disorders*** or ***substance use disorders***, will be deemed to include an institution which is licensed as a mental ***hospital*** or ***substance use disorder*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, or physical sickness. ***Pregnancy*** of a covered ***employee*** or their covered spouse shall be considered an ***illness***.

Incurred or Incurred Date

With respect to a ***covered expense***, the date the services, supplies or treatment are provided.

Independent Freestanding Emergency Department

A health care ***facility*** that is geographically separate and distinct and licensed separately from a ***hospital*** under applicable State law and provides ***emergency services***.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound.

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital***, ***hospice***, or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board***.

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician***.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care***. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital***;
2. Special life saving equipment which is immediately available at all times;
3. At least two beds for the accommodation of the critically ill; and
4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

Intensive Outpatient Treatment

An ***outpatient substance use disorder*** program that operates a minimum of (3) three hours per day at least (3) three days per week, which includes an individualized treatment plan consisting of assessment, counseling, crisis intervention, and activity therapies or education.

Late Enrollee

A ***covered person*** who did not enroll in the ***Plan*** when first eligible or as the result of a special enrollment period.

Layoff

A period of time during which the ***employee***, at the ***employer's*** request, does not work for the ***employer***, but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time***, active work. ***Layoffs*** will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of a stated duration after which time the ***employee*** is expected to return to active work.

Maximum Benefit [for Essential Health Benefits/non-***Essential Health Benefits]***

Any one of the following, or any combination of the following ***Essential Health Benefits/***non-***Essential Health Benefits***:

1. The maximum amount paid by the ***Plan*** for any one ***covered person*** during the entire time the ***covered person*** is covered by the ***Plan***.

2. The maximum amount paid by the ***Plan*** for any one ***covered person*** for a particular ***covered expense***. The maximum amount can be for:

    a. The entire time the ***covered person*** is covered under the ***Plan***, or
    b. A specified period of time, such as a calendar year.

3. The maximum number as outlined in the ***Plan*** as a ***covered expense***. The maximum number relates to the number of:

    a. Treatments during a specified period of time, or
    b. Days of ***confinement***, or
    c. Visits by a ***home health care agency***.

The ***maximum benefit*** for ***Essential Health Benefits*** and non-***Essential Health Benefits*** is tracked separately.

Measurement Period

The period of time, as determined by the ***employer*** and consistent with Federal law, regulation and guidance, utilized by the ***employer*** to determine whether a ***variable hour employee*** worked on average thirty (30) hours per week for the ***employer***.

Median Contracted Rate

The rate calculated by arranging in order from least to greatest all of the ***contracted rates*** in a geographic area for the same or similar item or service that is provided by a provider or ***facility*** in the same or similar specialty or ***facility*** type, and selecting the middle number. If there are an even number of ***contracted rates***, the ***median contracted rate*** is the average of the middle two ***contracted rates***. ***Median contracted rates*** are:

a. calculated separately for CPT code modifiers 26 (professional component) and TC (technical component);
b. based on an ***anesthesia conversion factor*** for each anesthesia service code;
c. based on air mileage service codes (A0435 and A0436) for air ambulance services; and
d. calculated separately for each service code-modifier, when ***contracted rates*** vary based on application of a modifier.

Medically Necessary (or Medical Necessity)

Service, supply or treatment which is determined by the ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** (or its designee) to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of medical practice within the United States; and

3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider***; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending ***professional provider***.

The fact that a ***professional provider*** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment ***medically necessary*** and the ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** (or its designee), may request and rely upon the opinion of a ***physician*** or ***physicians***. The determination of the ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** (or its designee) shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs; and Part D, Medicare Prescription Drug Benefit, including any subsequent changes or additions to those programs.

Mental Health Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Named Fiduciary for Post-Service Claim Appeals

Medical
Blue Cross Blue Shield Illinois.

Prescription Drug
Prime Therapeutics

Named Fiduciary for Pre-Service Claim Appeals

Medical
Quantum

Prescription Drug
Prime Therapeutics

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan***.

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy***.

Nonpreferred Provider

A ***physician***, ***hospital***, or other health care provider who does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.) or Doctorate of Nursing Practice (D.N.P.) who is practicing within the scope of their license.

Out-of-Network Rate

The final payment amount under this ***Plan*** for ***covered expenses*** from a ***nonpreferred provider*** is:

1. Subject to number 3. below, in a State that has in effect an applicable specified State law, the amount determined in accordance with such law.

2. Subject to number 3. below, if no applicable specified State law:

    a. Subject to number 2.b. below, the agreed amount if the ***nonpreferred provider*** and this ***Plan*** agree on an amount of payment (including if the amount agreed upon is the initial amount paid by this ***Plan*** or is agreed through negotiations); or
    b. The amount determined by the ***certified IDR entity***.

3. In a State that has an all-payer model agreement that applies to this ***Plan***, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if the ***covered person*** is treated at:

1. A ***hospital*** as other than an ***inpatient***;

2. A ***physician's*** office, laboratory or x-ray ***facility***; or

3. An ***ambulatory surgical facility***; and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement

A period of at least six (6) hours but less than twenty-four (24) hours per day of active treatment up to five (5) days per week in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.

2. Treatment of ***mental health disorders***.

3. ***Substance use disorder*** treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs which is contracted with the ***pharmacy benefit manager***.

Pharmacy Benefit Manager

The ***pharmacy benefit manager*** is Prime Therapeutics.

Physical Status Modifier

The standard modifier describing the physical status of the patient used to distinguish between various levels of complexity of an anesthesia service provided expressed as a unit with a value between zero (0) and three (3).

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person*** who is practicing within the scope of his license.

Placed For Adoption

The date the ***employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"***Plan***" refers to the benefits and provisions for payment of same as described herein. The ***Plan*** is the LSC Group Benefits Plan.

Plan Administrator

The ***plan administrator*** is responsible for the day-to-day functions and management of the ***Plan***. The ***plan administrator*** is the Benefits Committee, or other entity or individual designated by the Benefits Committee to supervise the administration of the ***Plan***.

Plan Sponsor

The ***plan sponsor*** is LSC Communications LLC.

Preferred Provider

A ***physician***, ***facility*** or other health care provider who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

The organization, designated by the ***plan administrator***, who selects and contracts with certain ***hospitals***, ***physicians***, and other health care providers to provide services, supplies and treatment to ***covered persons*** at a ***negotiated rate***. The ***Preferred Provider Organization's*** name and/or logo is shown on the front of the ***covered person's*** ID card.

Pregnancy

The physical state which results in childbirth or miscarriage.

Primary Care Physician (PCP)

A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a general or family practitioner, pediatrician, gynecologist/obstetrician or general internist.

Prior Plan

Any plan of group accident and health benefits provided by the ***employer*** (or its predecessor) for an employee group which has been replaced by coverage under this ***Plan***.

Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002).

Professional Provider

A licensed ***physician***; surgeon; or any other licensed practitioner required to be recognized by state law, if applicable, and performing services within the scope of such license, who is not a family member.

Qualified Prescriber

A ***physician***, ***dentist*** or other health care practitioner other than a ***close relative*** of the ***covered person*** who may, in the legal scope of their license, prescribe drugs or medicines.

Qualifying Payment Amount

a. For items or services furnished during 2022, the ***median contracted rate*** on January 31, 2019;
b. For items or services furnished after 2022, the ***median contracted rate*** in the immediately preceding year;
c. For items or services for which there is insufficient information to calculate the ***median contracted rate***, the ***qualifying payment amount*** will be calculated by identifying the rate that is equal to the median of the ***negotiated rates*** for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished determined through the use of any eligible database;

The amount in a., b., or c. above is increased for inflation in accordance with the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

d. For items or services furnished during 2022 and billed under a new service code where there is insufficient information to calculate the ***median contracted rates***, a reasonably related service code that existed in the immediately preceding year will be identified.

    i. If the Centers for Medicare & Medicaid Services has established a ***Medicare*** payment rate for the item or service billed under the new service code, the ***qualifying payment amount*** will be calculated by first calculating the ratio of the rate that ***Medicare*** pays for the new service code compared to the rate that ***Medicare*** pays for the related service code. This ratio is then multiplied by the ***qualifying payment amount*** for the related service code for the year in which the item or service is furnished.
    ii. If the Centers for Medicare & Medicaid Services has not established a ***Medicare*** payment rate for the item or service billed under the new service code, the ***qualifying payment amount*** will be calculated by first calculating the ratio of the rate that this ***Plan*** reimburses for the new service code compared to the rate this ***Plan*** reimburses for the related service code. This ratio is then multiplied by the ***qualifying payment amount*** for the related service code.

e. For items or services furnished after 2022 and billed under a new service code, the ***qualifying payment amount*** described in letter d. above will be increased for inflation in accordance with the percentage increase in the CPI-U published by federal regulators.
f. For anesthesia services furnished during 2022, the ***median contracted rate*** for the ***anesthesia conversion factor*** on January 31, 2019 increased for inflation in accordance with the increase in the CPI-U published by federal regulators (referred to as the indexed ***median contracted rate*** for the ***anesthesia conversion factor***), multiplied by the sum of the ***base unit***, time unit (measured in 15-minute increments or a fraction thereof), and ***physical status modifier*** unit. For anesthesia services furnished during 2023 or later, the indexed ***median contracted rate*** for the ***anesthesia conversion factor*** will be based on the same or similar item or service in the immediately preceding year.
g. For air ambulance services billed using air mileage service codes (A0435 and A0436), the ***median contracted rate*** increased for inflation in accordance with the increase in the CPI-U published by federal regulators (referred to as the indexed median ***air mileage rate***), multiplied by the number of loaded miles (the number of miles a patient is transported in the air ambulance vehicle).The ***qualifying payment amount*** for other service

codes associated with air ambulance services is calculated consistent with a. through e above.

h. For any other items or services where payment is determined by multiplying a ***contracted rate*** by another unit value, the ***qualifying payment amount*** for such items or services will be based on a calculation methodology similar to f. and g. above.

Recognized Amount

With respect to ***covered expenses*** furnished by a ***nonpreferred provider***:

a. Subject to letter c. of this definition, in a State that has in effect an applicable specified State law, the amount determined in accordance with such law;

b. Subject to letter c. of this definition, in a State that does not have in effect an applicable specified State law, the lesser of:

   i. The provider's actual charge; or
   ii. The ***qualifying payment amount***;

c. In a State that has an all-payer model agreement that applies to this ***Plan***, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Rehabilitative Services

Medically necessary health care services that help a ***covered person*** get back, keep, or improve skills for daily living that have been lost or impaired after sickness, ***injury***, or disability. These services assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. ***Rehabilitative services*** include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and psychiatric rehabilitation.

Relevant Information

Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or

2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or

3. That demonstrates compliance with the duties to make benefit decisions in accordance with ***Plan*** documents and to make consistent decisions; or

4. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

Required By Law

The same meaning as the term "required by law" as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

Retail Clinic

A clinic whose primary function is to provide limited routine medical services in a retail-based store location staffed with licensed ***professional providers***.

Room and Board

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in its ***semiprivate*** rooms containing two (2) or more beds.

Serious and Complex Condition

In the case of an acute ***illness***, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic ***illness*** or condition, a condition that:

1. Is life-threatening, degenerative, potentially disabling, or congenital; and

2. Requires specialized medical care over a prolonged period of time.

Stability Period

The period of time as determined by the ***employer*** and consistent with Federal law, regulation and guidance, after the ***measurement period*** has been completed.

Stabilize

To provide medical treatment of an ***emergency medical condition*** as necessary, to assure within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the ***covered person*** from a ***facility***, including delivery with respect to a pregnant woman who is having contractions.

Substance Use Disorder

Any disease or condition that is classified as a ***substance use disorder*** in the current edition of the International Classification of Diseases, in effect at the time services are rendered. The fact that a disorder is listed in the International Classification of Diseases or any other publication does not mean that treatment of the disorder is covered by this ***Plan***.

Telemedicine Services

Telephone or web-based video consultations and health information provided by a state licensed ***physician***. Such services include telebehavioral health or ***mental health disorder*** health services provided by a ***physician*** or other licensed provider.

Telemedicine Services Vendor

The ***telemedicine services vendor*** is *MDLive*.

Total Disability or Totally Disabled

The ***employee*** is prevented from engaging in the ***employee's*** regular, customary occupation due to ***illness*** or ***accident***, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health due to ***illness*** or ***accident***.

Treatment Center

1. An institution which does not qualify as a ***hospital***, but which does provide a program of effective medical and therapeutic treatment for ***substance use disorder***, and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

   a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
   b. It provides a program of treatment approved by the ***physician***.
   c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person***.
   d. It provides at least the following basic services:

      (i.) ***Room and board***
      (ii.) Evaluation and diagnosis
      (iii.) Counseling
      (iv.) Referral and orientation to specialized community resources.

Urgent Care

An ***emergency medical condition*** or an onset of severe pain that cannot be managed without immediate treatment.

Urgent Care Center

A ***facility*** which is engaged primarily in providing minor emergency and episodic medical care and which has:

1. a board-certified ***physician***, a Registered Nurse (RN) and a registered x-ray technician in attendance at all times;

2. has x-ray and laboratory equipment and life support systems.

An ***urgent care center*** may include a clinic located at, operated in conjunction with, or which is part of a regular ***hospital***.

Variable Hour Employee

An ***employee*** as defined by Federal law, regulation and guidance.

BlueCross BlueShield of Illinois

APPENDIX A

SurgeryPlus®
Benefit Description

SurgeryPlus® Overview

Enrollment in the SurgeryPlus® benefit is included with participation in LSC Communications LLC Copay Advantage Plan, HSA Value Plan and HSA Core medical plans. The SurgeryPlus benefit is a comprehensive surgical program that provides a personalized concierge experience from dedicated Care Advocates and access to quality-centric health care through a high-quality network of credentialed surgeons.

How It Works

When a ***covered person*** has a procedure using the SurgeryPlus benefit, a Care Advocate assists the ***covered person*** with coordinating the most suitable medical care. Care Advocates ensure the ***covered person*** has access to the best information as decisions are made about care, and he or she provides guidance throughout the process, answers any questions that may arise, and provides support in handling logistics throughout the course of treatment. Any related health care expenses are processed under the SurgeryPlus benefit, so the cost is known upfront.

Getting Started

The process of utilizing the SurgeryPlus benefit begins by speaking with a Care Advocate at **844-460-2803**. The Care Advocate will collect information about the ***covered person's*** health needs, and past medical treatments in order to best understand the ***covered person's*** unique needs. Once this information is obtained, the Care Advocate will schedule a consultation with the specialist selected from the SurgeryPlus, high-quality network of credentialed surgeons.

Plan Design and Program Incentives

The following Plan Designs will govern your out-of-pocket responsibility for services under the SurgeryPlus benefit:

Enrolled Health Plan	Deductible	Coinsurance	Financial Reward
Copay Advantage Plan	Collected	Waived	None
HSA Value Plan	Collected	Waived	None
HSA Core Plan	Collected	Waived	None

What SurgeryPlus Benefit Covers

The SurgeryPlus benefit specializes in covering planned surgical events in the following specializations:

Joint Replacement	Spine	Orthopedics	Ear, Nose & Throat (ENT)
Cardiac	Gastroenterology (GI)	Hernia Repair	Pain Management
Gallbladder Removal	Thyroid Removal	Gynecology (GYN)	Bariatrics

Limitations and Disclosures

The SurgeryPlus benefit is a service offered by Employer Direct Healthcare, LLC in providing non-clinical care coordination for planned medical procedures. Employer Direct Healthcare, LLC is not a health care provider and does not practice medicine, provide medical advice, or make any recommendation as to selection of any course of treatment or medical care. The ***covered person*** and their health care providers are solely responsible for making decisions regarding your medical care.

All claims paid by LSC Communications LLC health ***Plan*** for the SurgeryPlus benefit are considered in-network and included in the annual out-of-pocket expense limits. SurgeryPlus claims are subject to ERISA under the LSC Communications LLC health ***Plan***.

Any medical services performed by a health care provider that is not a participant in the SurgeryPlus network, including pre- and post-operative care, will not be covered by the SurgeryPlus benefit and will be subject to the coverage limits and other terms of LSC Communications LLC health ***Plan***. Additionally, any medical services which were not coordinated by a SurgeryPlus Care Advocate may not be covered by the SurgeryPlus benefit.

THE SURGERYPLUS® BENEFIT SHOULD NOT BE USED IN ANY SITUATION REQUIRING EMERGENT MEDICAL CARE. IN THE EVENT OF A MEDICAL EMERGENCY, A ***COVERED PERSON*** SHOULD CALL A DOCTOR, VISIT AN EMERGENCY ROOM FACILITY, OR CALL 911 IMMEDIATELY.