

Your Vision Care Benefit Program



Glenview School District #34 B56153

Administered

by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

A message from

BLUE CROSS AND BLUE SHIELD

This Vision Care Benefit Program plan is administered by Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield has contracted with EyeMed Vision Care, LLC, also referred to as the “vision care plan administrator.” EyeMed provides customer service, and Claims administration services and for Members enrolled in the *Vision Care Benefit Program*. The relationship between Blue Cross and Blue Shield and EyeMed is that of independent contractors. Through our arrangement with EyeMed, you will have access to EyeMed’s extensive network of vision care Providers.

Like most people, you probably have many questions about your coverage. The Certificate contains information about the services and supplies for which Benefits will be provided under your vision plan. Please read your entire Certificate very carefully. We hope that most of the questions you have about your coverage will be answered.

In this Certificate, we refer to our company, Blue Cross and Blue Shield and the vision care plan administrator, EyeMed as the “the Plan” and we refer to the company that you work for as the “Group”. The Definitions Section will explain the meaning of many of the terms used in this Certificate. All terms used in this Certificate, when defined in the Definitions Section, begin with a capital letter. Whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

Blue Cross and Blue Shield EyeMed and/or your Group may change the Benefits described in this Certificate. If that happens, Blue Cross and Blue Shield EyeMed and/or your Group will notify you of those mutually agreed upon changes. If you have any questions once you have read this Benefit Booklet, talk to your Benefits administrator or call us at the number listed on the back of your Vision Identification Card. It is important to all of us that you understand the protection this coverage gives you.

Welcome to the *Vision Care Benefit Program*! We are very happy to have you as a Member and pledge you our best service,

Sincerely,

Blue Cross and Blue Shield of Illinois

A Division of Health Care Service Corporation



A Mutual Legal Reserve Company
Stephen Harris, President Illinois Division

NOTICE

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

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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BENEFIT HIGHLIGHTS

Your benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire Certificate.

VISION CARE BENEFITS		
Eye Examination Once Every 12 months		No Copayment
Standard Conventional & Disposable Fit & Follow up Premium Conventional & Disposable Fit & Follow up Once Every 12 months		No Copayment No Copayment, 10% off the Provider's Retail Price, then Apply \$40 Allowance
Frames Once Every 24 months		No Copayment, \$125 Allowance
Standard Plastic Lenses Once Every 24 months	Single Vision Lenses	No Copayment
	Bifocal Lenses	No Copayment
	Trifocal Lenses	No Copayment
	Lenticular Lenses	No Copayment
Lens Options	Standard Polycarbonate - Kids under 19	No Copayment
Contact Lenses Once every 24 months	Conventional	No Copayment, then apply \$75 Allowance
	Disposables	No Copayment, then apply \$75 Allowance
	Medically Necessary	No Copayment, Paid in Full
*Value Added Features – Participating Providers may offer Discounted Prices for Non-Covered Lenses		

Lens Options	Standard Progressive Lens*	Up to \$65
	Premium Progressive Lens Tier 1*	Up to \$85
	Premium Progressive Lens Tier 2*	Up to \$95
	Premium Progressive Lens Tier 3*	Up to \$110
	Premium Progressive Lens Tier 4*	Up to \$65 Copay, 80% of Charge less \$120 Allowance
	Tint (Solid and Gradient)*	Up to \$15
	UV Treatment*	Up to \$15
	Standard Plastic Scratch Coating*	Up to \$15
	Standard Polycarbonate – Adults*	Up to \$40
	Standard Anti-Reflective Coating*	Up to \$45
	Premium Anti-Reflective Coating Tier 1*	Up to \$57
	Premium Anti-Reflective Coating Tier 2*	Up to \$68
	Standard Anti-Reflective Coating Tier 3*	Up to 20% off Retail Price
	Photochromic/Transitions Plastic*	Up to \$75
	Other Add-Ons*	Up to 20% off Retail Price

OUT-OF-NETWORK REIMBURSEMENT

No OON Benefits Available

Note 1: Contact lens allowance includes materials only and are in lieu of spectacle lenses.

Note 2: Medically necessary contact lenses are covered in lieu of other eyewear.

*Note 3: Discounted prices may vary by state and are subject to change or discontinuance at any time without notice. **THE DISCOUNTS ARE NOT INSURANCE.***

DEFINITIONS

Throughout this Certificate, many words are used which have a specific meaning when applied to your vision care coverage. The definitions of these words are listed below in alphabetical order. These defined words will always be capitalized when used in this Certificate.

CERTIFICATE.....means this booklet and your application for coverage under the Plan benefit program described in this booklet.

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

CLAIM.....means a properly completed notification in a form acceptable to Claim Administrator, including but not limited to, form and content required by applicable law, that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes), the Claim Charge, and any other information which Claim Administrator may request in connection for such service.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for services rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Plan and a particular Provider. (See provisions of this Certificate regarding "Plan's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by the Plan, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Provider's Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Plan and a particular Provider. (See provisions of this Certificate regarding "Plan's Separate Financial Arrangements with Providers.")

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1958 P.L. 99-272, as amended which regulate the conditions and manner under which an Employer can offer continuation of group health insurance to employees and their family members whose coverage would otherwise terminate under the terms of this Certificate.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COVERAGE DATE.....means the date on which your coverage under this Certificate begins, as shown on the Benefit Highlights Page.

COVERED SERVICE.....means a service or supply specified in this Certificate for which benefits will be provided.

ELIGIBLE PERSON.....means an employee of the Group who meets the eligibility requirements for this vision coverage and has medical coverage under Blue Cross Blue Shield Plan, as described in the ELIGIBILITY SECTION of this Certificate.

FAMILY COVERAGE.....means coverage for you and your eligible spouse and/or dependents under this Certificate.

GROUP POLICY OR POLICY.....means the agreement between the Plan and the Group, and any addenda, and this Certificate, and the Benefit Program Application of the Group, as appropriate, along with any exhibits, appendices, addenda and/or other required information and the individual application(s) of the persons covered under the Policy.

INDIVIDUAL COVERAGE.....means that your application for coverage was only for yourself but not your spouse and/or dependents.

EXPERIMENTAL/INVESTIGATIONAL.....means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided. Approval by a Federal Agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

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

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

- Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- Are appropriate for the Hospital or Facility Other Provider in which they were performed; and

- The Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

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

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

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS CERTIFICATE.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.)

MEDICARE SECONDARY PAYER OR MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain Employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

NON-PARTICIPATING OPTOMETRIST.....SEE DEFINITION OF OPTOMETRIST.

NON-PARTICIPATING VISION CARE PROVIDER.....means a Vision Care Provider which does not have a written agreement with the Plan.

OPTOMETRIST.....means a duly licensed optometrist operating within the scope of his/her license.

A “Participating Optometrist” means an Optometrist who has a written agreement with Blue Cross and Blue Shield of Illinois, with the entity chosen by Blue Cross and Blue Shield to administer its vision benefit program, or with another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with Blue Cross and Blue Shield of Illinois, with the entity chosen by Blue Cross and Blue Shield to administer its vision benefit program, or with another Blue Cross

and/or Blue Shield Plan to provide services to you at the time services are rendered.

PARTICIPATING OPTOMETRIST.....SEE DEFINITION OF OPTOMETRIST.

PARTICIPATING PROVIDER OPTION.....means a program of vision care benefits designed to provide you with economic incentives for using designated Providers of vision care services.

PARTICIPATING VISION CARE PROVIDER.....means a Vision Care Provider which has a written agreement with the Plan.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches, operating within the scope of his/her license.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician.

PLAN PROVIDER.....SEE DEFINITION OF PROVIDER.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician, Optometrist, or Pharmacy) duly licensed to render Covered Services to you.

A “Plan Provider” means a Provider which has a written agreement with Blue Cross and Blue Shield of Illinois, with the entity chosen by Blue Cross and Blue Shield to administer its vision benefit program, or with another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Plan Provider” means a Provider that does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

RESCISSION.....means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums.

VISION CARE PROVIDER.....means any individual, partnership, proprietorship or organization lawfully and regularly engaged in the business of prescribing and/or dispensing corrective lenses prescribed by a Physician, Optometrist or Optician.

THINGS YOU SHOULD KNOW

Vision Materials must be purchased from an In-Network Provider in order to receive discount. Also, none of these services and products covered under the *Vision Care Benefit Program* count toward medical/surgical plan deductibles or out-of-pocket limits under any medical/surgical plan you may have.

This Certificate describes the Benefits available to Members of the *Vision Care Benefit Program*. If after reading it, you still have questions, please contact EyeMed Customer Service.

CUSTOMER SERVICE

Questions about services covered under the *Vision Care Benefit Program*, In-Network vision plan Providers, or about Benefits provided or denied under the Plan can be directed to EyeMed seven days a week.

EyeMed Vision Care, LLC
Call 1-844-684-2254 or click the online link to
www.eyemed.com

Hours: Central Time
Monday through Saturday 6:30 A.M. to 10:00 P.M.
Sunday 10:00 A.M. to 7:00 P.M.

An Interactive Voice Response unit is also available outside normal business operating hours. (Please direct Member enrollment, termination, and other Subscriber or Eligible Family Member's eligibility questions to Blue Cross and Blue Shield AT 1-800-892-2803 – not to EyeMed.)

Members who use a TTY (Teletypewriter) may access TTY services by calling or using a TTY machine to engage an operator at 711 and asking the operator to call EyeMed at 1-844-230-6498 or Blue Cross and Blue Shield and phone number. Customer service hours and operations are subject to change without notice.

ELIGIBILITY

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

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

- Meet the definition of an Eligible Person as specified in the Group Policy;
- Have applied for this coverage; and have medical healthcare coverage under the Blue Cross Blue Shield Medical Plan
- Have received an EyeMed Identification card.
- If Medicare eligible, have both Part A and B coverage.

APPLYING FOR COVERAGE

You may apply for coverage for yourself and/or your spouse, party to a Civil Union and/or dependents (see below) by submitting the application(s) for medical insurance form, along with any exhibits, appendices, addenda and/or other required information (“Application(s)”) to the Plan.

You can get the application form from your Group Administrator. An application to add a newborn to Family Coverage is not necessary if an additional premium is not required. However, you must notify your Group Administrator within 31 days of the birth of a newborn child for coverage to continue beyond the 31 day period or you will have to wait until your Group’s open enrollment period to enroll the child.

The Application(s) for coverage may or may not be accepted. Please note, some Employers only offer coverage to their employees, not to their employees’ spouses, parties to a Civil Union or dependents. In those circumstances, the references in this Certificate to an employee’s family members are not applicable.

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

You may enroll in or change coverage for yourself and/or your eligible spouse and/or dependents during one of the following enrollment periods. Your and/or your eligible spouse and/or dependents’ effective date will be determined by the Plan depending upon the date your application is received and other determining factors.

The Plan may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an Eligible Person under this Certificate.

ANNUAL OPEN ENROLLMENT PERIOD/ EFFECTIVE DATE OF COVERAGE

Your Group will designate annual open enrollment periods during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union and/or dependents.

This section “Annual Open Enrollment Period/Effective Date of Coverage” is subject to change by the Plan, and/or applicable law, as appropriate.

SPECIAL ENROLLMENT PERIODS

Special Enrollment Periods/Effective Dates of Coverage

Special enrollment periods have been designated during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Unions and/or dependents. You must apply for or request a change in coverage within 31 days from the date of a special enrollment event, except as otherwise provided below, in order to qualify for the changes described in this Special Enrollment Periods/Effective Dates of Coverage section.

Except as otherwise provided below, if you apply between the 1st day and the 15th day of the month, your effective date will be no later than the 1st day of the following month, or if you apply between the 16th day and the end of the month, your and your eligible spouse, party to a Civil Union and/or dependent’s effective date will be no later than the 1st day of the second following month.

You must provide acceptable proof of a qualifying event with your application. Special enrollment qualifying events are discussed in detail below. The Plan will review this proof to verify your eligibility for a special enrollment. Failure to provide acceptable proof of a qualifying event with your application will delay or prevent the processing of your application and enrollment in coverage. Please call the customer service number on the back of your identification card or visit www.bcbsil.com for examples of proof for qualifying events.

Special Enrollment Events:

- a. You gain or lose a dependent or become a dependent through marriage, or becoming a party to a Civil Union . New coverage for you and/or your eligible spouse, party to a Civil Union and/or dependents will be effective on the date of the qualifying event, so long as you apply 31 days from the qualifying event date. If you apply any later than 31 days from the qualifying event date, coverage for your spouse, party to a Civil Union and/or dependents will be effective no later than the 1st day of the following month.
- b. You gain or lose a dependent through birth, placement of a foster child, adoption or placement of adoption or court-ordered dependent coverage. New coverage for you and/or your eligible spouse, party to a Civil Union , and/or dependents will be effective on the date of the

birth, placement of a foster child, adoption, or placement of adoption. However, the effective date for court-ordered eligible child coverage will be determined by the Plan in accordance with the provisions of the court-order.

- c. You lose eligibility for coverage under a Medicaid plan or a state child health plan under title XXI of the Social Security Act. You must request coverage within 60 days of the loss of coverage.
- d. You become eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or state child health plan. You must request coverage within 60 days of such eligibility.

This section “Special Enrollment Periods/Effective Date of Coverage” is subject to change by the Plan and/or applicable law, as appropriate.

Other Special Enrollment Events/Effective Dates of Coverage:

You must apply for or request a change in coverage within 31 days from the date of the below other special enrollment events in order to qualify for the changes described in this Other Special Enrollment Events/Effective Dates of Coverage section. Except as otherwise provided below, if you apply between the 1st day and the 15th day of the month, your effective date will be the 1st day of the following month, or if you apply between the 16th day and the end of the month, your and your eligible spouse, party to a Civil Union and/or dependent’s effective date will be the 1st day of the second following month.

1. Loss of eligibility as a result of:
 - Legal separation, divorce, or dissolution of a Civil Union;
 - Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent child under this Certificate);
 - Death of an Employee;
 - Termination of employment, reduction in the number of hours of employment.
2. Loss of coverage through an HMO in the individual market because you and/or your eligible spouse, party to a Civil Union and/or dependents no longer reside, live or work in the network service area.
3. Loss of coverage through an HMO, or other arrangement, in the group market because you and/or your eligible spouse, party to a Civil Union and/or dependents no longer reside, live or work in the network service area, and no other coverage is available to you and/or your eligible spouse, party to a Civil Union and/or dependents.
4. Loss of coverage due to a plan no longer offering benefits to the class of similarly situated individuals that include you.
5. Your Employer ceases to contribute towards your or your dependent’s coverage (excluding COBRA continuation coverage).

6. COBRA continuation coverage is exhausted.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the Application(s) and remittance of the appropriate premiums in accordance with the guidelines as established by the Plan. Your spouse, party to a Civil Union and other dependents are not eligible for a special enrollment period if the Group does not cover dependents.

This section “Other Special Enrollment Periods/Effective Date of Coverage” is subject to change by the Plan and/or applicable law, as appropriate.

NOTIFICATION OF ELIGIBILITY CHANGES

It is the Eligible Person’s responsibility to notify the Plan of any changes to an Eligible Person’s name or address or other changes to eligibility. Such changes may result in coverage/benefit changes for you and your eligible dependents.

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

Under Family Coverage, your vision care expenses and those of your enrolled spouse, party to a Civil Union and your (and/or your spouse, party to a Civil Union) enrolled children who are under the limiting age specified below will be covered.

All of the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise.

“Child(ren)” used hereafter in this Certificate, means a natural child(ren), a stepchild(ren), adopted child(ren), foster child(ren) a child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, a child(ren) of your child(ren), grandchild(ren), child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child’s financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. In addition, enrolled unmarried children will be covered up to the age of 30 if they:

- Live within the state of Illinois
- Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
- Have received a release or discharge other than a dishonorable discharge.

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

coverage because of a serious illness or injury will terminate 12 months after notice of the illness or injury.

Coverage for children will end on the last day of the calendar month in which the limiting age birthday falls.

If you have Family Coverage, newborn children will be covered from the moment of birth. Please notify the Plan within days of the birth so that your membership records can be adjusted. Your Group Administrator can tell you how to submit the proper notice through the Plan.

Children who are under your legal guardianship or who are in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, and foster children will be covered. In addition, if you have children for whom you are required by court order to provide health care coverage, those children will be covered.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care Providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age as long as they were covered prior to reaching the limiting age specified below.

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

Coverage under this Certificate is contingent upon timely receipt by the Plan of necessary information and initial premium.

MEDICARE ELIGIBLE COVERED PERSONS

A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain Employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children. Reference to spouse under this section do not include a party to a Civil Union with the Eligible Person, or their children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and Employer group health plan (“GHP”) coverage, as well as certain other factors, including the size of the Employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the Employer or whether the individual has “current employment status.”
2. In the case of individuals age 65 or over, GHPs of Employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-Employer or multiple Employer plan, which has at least one participating Employer that employs 20 or more employees, the MSP rules apply even with respect to Employers of fewer than 20 employees (unless the plan elects the small Employer exception under the statute).

3. In the case of disabled individuals under age 65, GHPs of Employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-Employer plan, which has at least one participating Employer that employs 100 or more employees, the MSP rules apply even with respect to Employers of fewer than 100 employees.

Please see your Employer or Group Administrator if you have any questions regarding the ESRD Primary Period or any other provisions of the MSP laws and their application to you, your spouse or your dependents.

Your MSP Responsibilities

In order to assist your Employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Plan and/or your Employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your Employer or your group administrator promptly to ensure that your claims are processed in accordance with applicable MSP laws.

YOUR IDENTIFICATION CARD

You will receive an identification (ID) card from the Plan. Your ID card contains your identification number, the name of the Participating IPA/Participating Medical Group that you have selected and the phone number to call in an emergency. Before you go to a Participating Vision Provider for an eye examination, eyeglasses, or contact lenses, please call ahead for an appointment. When you arrive, show the receptionist your identification card. If you forget to take your card, be sure to say that you are a member of the Blue Cross and Blue Shield vision care plan so that your eligibility can be verified. Please note that ID cards are not required to receive services – all EyeMed In-Network Providers can verify a member's eligibility with a name and date of birth. Further, the ID cards can be used by anyone in the member's family who is also covered by the Plan. If you want additional cards or need to replace a lost or stolen card, contact customer service or go to www.eyemed.com web here and get a card online. Always carry your ID card with you.

LATE APPLICANTS

If you do not apply for Family Coverage or to add dependents within the allotted time, you will have to wait until your Group's annual open enrollment period to do so.

TERMINATION OF COVERAGE

If the Plan terminates your coverage under this Certificate for any reason, the Plan will provide you with a notice of termination of coverage that includes the termination effective date and the reason for termination at least 30 days prior to the last day of coverage, except as otherwise provided in this Certificate.

You and your eligible spouse, party to a Civil Union and/or dependents' coverage will be terminated due to the following events and will end on the dates specified below:

- a. The termination date specified by you, if you provide reasonable notice.
- b. When the Plan does not receive the full amount of the premium payment or other charge or amount on time or when there is a bank draft failure of premiums for your and/or your eligible spouse, party to a Civil Union and/or dependents' coverage and the grace period, if any, has been exhausted.
- c. You no longer have medical health insurance coverage under the Blue Cross Blue Shield Plan.
- d. Your coverage has been rescinded.
- e. In the case of intentional fraud or material misrepresentation.
- f. If you no longer meet the previously stated description of an Eligible Person.
- g. If the entire coverage of your Group terminates.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Other options available for continuation of coverage are explained in the Continuation of Coverage After Terminations Sections of this Certificate.

Termination of a Dependent's Coverage

If one of your dependents no longer meets the description of an eligible family member as given above under the heading "Family Coverage," his/her coverage will end as of the date the event occurs which makes him/her ineligible (for example, date of divorce). Coverage for children will end on the last day of the calendar month in which they reach the limiting age as shown in this Certificate.

WHO IS NOT ELIGIBLE

- a. Non-citizens or non-nationals of the United States, or individuals who are non-citizens and not lawfully present in the United States, and are not reasonable expected to be a citizen, national, or a non-citizen, who is not lawfully present for the entire period for which open enrollment is sought. Please see the Initial and Annual

Open Enrollment Periods/Effective Date of Coverage Section of this Certificate.

- b. Incarcerated individuals, other than incarcerated individuals pending disposition of charges.
- c. Individuals that do not meet the Plan's eligibility requirements or residency standards, as appropriate.

This section "WHO IS NOT ELIGIBLE" is subject to change by the Plan and/or applicable law, as appropriate.

VISION CARE PROGRAM

Your coverage includes benefits for vision care when you receive such care from a Physician, Optometrist or Optician.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY, and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Definitions

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

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

Frame......means a standard eyeglass frame adequate to hold Lenses.

Lenses......means ophthalmic corrective lenses, either glass or plastic, ground or molded to improve visual acuity and to be fitted to a Frame.

Optician......means a duly licensed optician.

Optometrist......means a duly licensed optometrist.

Vision Care Provider......means any individual, partnership, proprietorship or organization lawfully and regularly engaged in the business of prescribing and/or dispensing corrective lenses prescribed by a Physician, Optometrist or Optician.

A **“Participating Vision Care Provider”** is a Vision Care Provider which has a written agreement with the Plan.

A **“Non-Participating Vision Care Provider”** is a Vision Care Provider which does not have a written agreement with the Plan. Non-Participating Vision Care Providers are considered Out-of-Network.

COVERED SERVICES

Benefits will be provided under this Benefit Section for the following per Benefit Period:

- Vision Examination
- Single Vision Lenses
- Bifocal Lenses
- Trifocal Lenses
- Lenticular Lenses
- Lenses (other than Contact Lenses)
- Contact Lenses
- Frames

SPECIAL LIMITATIONS

Your vision care coverage does not include benefits for:

1. Recreational sunglasses;
2. medical or surgical treatment;
3. orthoptics, vision training, subnormal vision aids, aniseikonic Lenses or tonography; additional charges for tinted, photo-sensitive or anti-reflective Lenses beyond the benefit allowance for regular Lenses;
4. Replacement of Lenses, Frames or Contact Lenses which are lost or broken unless such Lenses, Frames or Contact Lenses would otherwise be covered according to the benefit period limitations specified above;

VALUE ADDED FEATURES*

Participating Providers may offer discounts on the price of some Non-covered services such as:	
Laser Vision Correction	Members receive 15% off the standard price or 5% off any promotional price for treatments performed through the U.S. Laser Network. For more information, call at 1-844-684-2254 or visit www.eyemed.com .
Contact Lens	Conventional contact lenses will receive a discount of 15% off the purchase price. and disposable contact lenses a 10% discount.
Additional Pairs	You will receive a 40% discount off complete pairs of prescription eyeglass purchases and a 15% discount off conventional contact lenses, once the funded benefit has been used.
Lenses	Check with your Provider for more information on potential discounts for Oversize Lenses, Tinting of Plastic Lenses, Scratch-Resistant Coating, Polycarbonate Lenses, Ultraviolet Coating, Standard Anti-Reflective (AR) Coating, Premier AR Coating, Ultra AR Coating

*Prices/discounts may vary by state and are subject to change without notice.

EXCLUSIONS: WHAT IS NOT COVERED

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

Hospitalization, services or supplies which are not Medically Necessary. PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH HEALTH CARE BENEFITS AT A REASONABLE COST, THE CERTIFICATE PROVIDES BENEFITS ONLY FOR THOSE COVERED SERVICES FOR ELIGIBLE HOSPITALIZATION, CARE, TREATMENT, SERVICES AND SUPPLIES THAT ARE MEDICALLY NECESSARY. IT DOES NOT PAY THE COST OF HOSPITALIZATION OR ANY OTHER HEALTH CARE SERVICES AND SUPPLIES THAT THE PLAN DETERMINES WERE NOT MEDICALLY NECESSARY.

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

- Services or supplies that are not specifically stated in this Certificate;
- Services and materials that are experimental or investigational;
- Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form or charges for the transfer of medical records;
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Any services that are strictly cosmetic in nature including but not limited to, charges for personalization or characterization of prosthetic appliances;

- Services or materials provided as a result of intentionally self-inflicted injury or illness;
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- State or territorial taxes on vision services performed;
- Medical treatment of eye disease or injury;
- Visual therapy;
- Special lens designs or coatings other than those described in this policy;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel operating within the scope of his/her license;
- Prosthetic devices and services;
- Insurance of contact lenses;

COORDINATION OF BENEFITS SECTION

NOTE: If your Group purchased this coverage in conjunction with a Health Savings Account, this COORDINATION OF BENEFITS SECTION does not apply to you.

Coordination of Benefits (COB) applies to this Benefit Program when you or your covered dependent(s) has vision care coverage under more than one Benefit Program.

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

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

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

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

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

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

BENEFIT PROGRAM.....means any of these which provide benefits or services for, or because of, medical or vision care or treatment:

- (i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.
- (ii) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION

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

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

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

1. Non-Dependent or Dependent

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

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

2. Dependent Child if Parents not Separated or Divorced

Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a dependent of different persons, called “parents:”

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

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

3. Dependent Child if Parents Separated or Divorced

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

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

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

4. Dependent Child if Parents Share Joint Custody

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

5. Active or Inactive Employee

The benefits of a Benefit Program which covers a person as an employee who is neither laid off nor retired (or as that employee’s dependent) are determined before those of a Benefit Program which covered that person as a laid off or retired employee (or as that employee’s dependent). If the

other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage

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

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

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

7. Length of Coverage

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

The benefits of this Benefit Program will be reduced when the sum of:

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

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any

other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Benefit Program must give the Plan any facts it needs to pay the Claim.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

1. The person(s) it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER CORBA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event know as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lost your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lost your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hour of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent's child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation of coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation of Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or

both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws)

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the Eligible Person (as specified in the Group Policy) at the time of termination. The provisions described in Article B will apply if you are the spouse of a retired Eligible Person or the party to a Civil Union with a retired Eligible Person and are at least 55 years of age or the former spouse of an Eligible Person or the former party to a Civil Union with a retired Eligible Person who has died or from whom you have been divorced or from whom your Civil Union has been dissolved. The provisions described in Article C will apply if you are the dependent child of an Eligible Person who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided under Article B.

Your continued coverage under this Certificate will be provided only as specified below. Therefore, after you have determined which Article applies to you, please read the provisions very carefully.

ARTICLE A: Continuation of coverage if you are the Eligible Person

If an Eligible Person's coverage under this Certificate should terminate because of termination of employment or membership or because of a reduction in hours below the minimum required for eligibility, an Eligible Person will be entitled to continue the Hospital, Physician and Supplemental coverage provided under this Certificate for himself/herself and his/her eligible dependents (if he/she had Family Coverage on the date of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation of coverage will be available to you only if you have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least 3 months prior to your termination date or reduction in hours below the minimum required for eligibility.
2. Continuation of coverage will not be available to you if: (a) you are covered by Medicare or (b) you have coverage under any other health care program which provides group hospital, surgical or medical coverage and under which you were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility, or (c) you decide to become a member of the Plan on a "direct pay" basis.
3. If you decide to become a member of the Plan on a "direct pay" basis, you may not, at a later date, elect the continuation of coverage option under this Certificate. Upon termination of the continuation of coverage period as explained in paragraph 6 below, you may exercise the Conversion Privilege explained in the ELIGIBILITY section of this Certificate.

4. Within 10 days of your termination of employment or membership or reduction in hours below the minimum required for eligibility, your Group will provide you with written notice of this option to continue your coverage. If you decide to continue your coverage, you must notify your Group, in writing, no later than 30 days after your coverage has terminated or reduction in hours below the minimum required for eligibility or 30 days after the date you received notice from your Group of this option to continue coverage. However, in no event will you be entitled to your continuation of coverage option more than 60 days after your termination or reduction in hours below the minimum required for eligibility.
5. If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by the Plan for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to the Plan (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.
6. Continuation of coverage under this Certificate will end on the date you become eligible for Medicare, become a member of Blue Cross and Blue Shield on a “direct pay” basis or become covered under another health care program (which you did not have on the date of your termination or reduction in hours below the minimum required for eligibility) which provides group hospital, surgical or medical coverage. However, your continuation of coverage under this Certificate will also end on the first to occur of the following:
 - a. Twelve months after the date the Eligible Person’s coverage under this Certificate would have otherwise ended because of termination of employment or membership or reduction in hours below the minimum required for eligibility.
 - b. If you fail to make timely payment of required charges, coverage will terminate at the end of the period for which your charges were paid.
 - c. The date on which the Group Policy is terminated. However, if this Certificate is replaced by similar coverage under another group policy, the Eligible Person will have the right to become covered under the new coverage for the amount of time remaining in the continuation of coverage period.

ARTICLE B: Continuation of Coverage if you are the former spouse of an Eligible Person or spouse of a retired Eligible Person

If the coverage of the spouse of an Eligible Person should terminate because of the death of the Eligible Person, a divorce from the Eligible Person, dissolution of a Civil Union from the Eligible Person, or the retirement of an Eligible Person, the former spouse or retired Eligible Person’s spouse if at least 55 years of age, will be entitled to continue the coverage provided under this Certificate for himself/herself and his/her eligible dependents (if Family Coverage is in

effect at the time of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the former spouse of an Eligible Person or spouse of a retired Eligible Person only if you provide the Employer of the Eligible Person with written notice of the dissolution of marriage or Civil Union, the death or retirement of the Eligible Person within 30 days of such event.
2. Within 15 days of receipt of such notice, the Employer of the Eligible Person will give written notice to the Plan of the dissolution of your marriage or Civil Union to the Eligible Person, the death of the Eligible Person or the retirement of the Eligible Person as well as notice of your address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of such notice from the Employer of the Eligible Person, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents under this Certificate may be continued. The Plan's notice to you will include the following:
 - a. a form for election to continue coverage under this Certificate.
 - b. Notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
 - c. Instructions for returning the election form within 30 days after the date it is received from the Plan.
3. In the event you fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Eligible Person under this Certificate as a result of the dissolution of marriage or Civil Union, the death or the retirement of the Eligible Person. Your right to continuation of coverage will then be forfeited.
4. If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all Eligible Persons under this Certificate.
5. If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:
 - a. an amount, if any, that would be charged to you if you were an Eligible Person, with Individual or Family Coverage, as the case may be, plus
 - b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

6. If you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginnings with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.

7. Termination of Continuation of Coverage:

If you have not reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

- a. If you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
- b. On the date coverage would otherwise terminate under this Certificate if you were still married to or in a Civil Union with the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.
- c. the date on which you remarry or enter another Civil Union.
- d. the date on which you become an insured employee under any other group health plan.
- e. the expiration of 2 years from the date your continued coverage under this Certificate began.

8. If you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

- a. If you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
- b. On the date coverage would otherwise terminate, except due to the retirement of the Eligible Person under this Certificate if you were still married to or in a Civil Union with the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death, retirement or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.
- c. The date on which you remarry or enter another Civil Union.
- d. The date on which you become an insured employee under any other group health plan.

- e. The date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.
9. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.
10. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of the Plan on a “direct pay” basis as specified in the Conversion Privilege of the ELIGIBILITY section of this Certificate.
11. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

ARTICLE C: Continuation of Coverage if you are the dependent child of an Eligible Person

If the coverage of a dependent child should terminate because of the death of the Eligible Person and the dependent child is not eligible to continue coverage under ARTICLE B or the dependent child has reached the limiting age under this Certificate, the dependent child will be entitled to continue the coverage provided under this Certificate for himself/herself. However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the dependent child of an Eligible Person only if you, or a responsible adult acting on your behalf as the dependent child, provide the Employer of the Eligible Person with written notice of the death of the Eligible Person within 30 days of the date the coverage terminates.
2. If continuation of coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the Eligible Person with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.
3. Within 15 days of receipt of such notice, the Employer of the Eligible Person will give written notice to the Plan of the death of the Eligible Person or of the dependent child reaching the limiting age, as well as notice of the dependent’s child address. Such notice will include the Group number and the Eligible Person’s identification number under this Certificate. Within 30 days of receipt of notice from the Employer of the Eligible Person, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. The Plan’s notice to you will include the following:
 - a. a form for election to continue coverage under this Certificate.
 - b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.

- c. instructions for returning the election form within 30 days after the date it is received from the Plan.
4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to the Plan within 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a dependent child of an Eligible Person under this Certificate as a result of the death of the Eligible Person or the dependent child attaining the limiting age. Your right to continuation of coverage will then be forfeited.
5. If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all Eligible Persons under this Certificate.
6. The monthly charge will be computed as follows:
 - a. an amount, if any, that would be charged to you if you were an Eligible Person, plus
 - b. an amount, if any, that the Employer would contribute toward the charge if you were the Eligible Person under this Certificate.

Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

7. Continuation of Coverage shall end on the first to occur of the following:
 - a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
 - b. on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the Eligible Person.
 - c. the date on which you become an insured employee, after the date of election, under any other group health plan.
 - d. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.
9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.

10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

The purpose of this provision of your Certificate is to explain the options available for temporarily continuing your coverage after termination if you are covered under this Certificate as the party to a Civil Union with an Eligible Person or as the dependent child of a party to a Civil Union with an Eligible Person. Your continued coverage under this Certificate will be provided only as specified below. Please read the provisions very carefully.

CONTINUATION OF COVERAGE

If you are a dependent who is party to a Civil Union or their child and you lose coverage under this Certificate, the options available to a spouse or a dependent child are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union Partnership with the Eligible Person terminates. Your Civil Union Partnership will terminate if your partnership no longer meets the criteria described in the definition of “Civil Union” in the DEFINITIONS section of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

HOW TO FILE A CLAIM

In order to obtain your benefits under this Certificate, it is necessary for a Claim to be filed with Blue Cross and Blue Shield. To file a Claim, usually all you will have to do is show your Blue Cross and Blue Shield ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember, however, it is your responsibility to insure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

Once Blue Cross and Blue Shield receives your Claim, it will be processed. The benefit payment for eligible Claims will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases, Blue Cross and Blue Shield will send the payment directly to you (for example, when you have already paid your Physician) or executed a valid Assignment of Benefits, as described below.

In certain situations, you will have to file your own Claims. There may be situations when you have to file your own Claim. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

- a. Complete a Claim Form. These are available from Blue Cross and Blue Shield at www.bcbsil.com. In addition, upon receipt of a notice of a claim, Blue Cross and Blue Shield will furnish to you the Claim Form(s) within 15 days. If Blue Cross and Blue Shield does not provide the Claim Form within such 15 days, you will be deemed to have complied with the Claim filing requirements of this Certificate for such Claim upon submitting, within the time period required by this Certificate, written proof of such Claim along with the details required by subsection (b) below.
- b. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis (including appropriate codes), the date of service and a description of the service (including appropriate codes) and the Claim Charge.
- c. Mail the completed Claim Form with attachments to:

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

In any case, Claims must be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished in the succeeding calendar year.) For purposes of this filing time limit, Covered Services rendered in the last month of a particular calendar year will be considered to have been rendered in the next calendar year. **Claims not filed within the required time period will not be eligible for payment.**

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

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

If a Claim Is Denied or Not Paid in Full

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

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

- Your health care coverage was rescinded

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

- c. An explanation that you may ask for an expedited (urgent) external review if:
 - Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health or ability to regain maximum function;
 - Blue Cross and Blue Shield failed to give you a decision within 48 hours of your request for an expedited appeal; or
 - The request for treatment is experimental or investigational and your health care Provider states in writing that the treatment would be much less effective if not promptly started;
 - d. If the written notice is for a Final Adverse Determination, the notice will include an explanation that you may ask for an expedited (urgent) external review if the Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.
 - e. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield sends you a written decision for appeals that need medical review within 15 business days after we receive any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. Decisions on expedited appeals are considered timely if Blue Cross and Blue Shield sends you a written decision with 48 hours of your request for an expedited appeal;
6. In certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
 7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield.
 8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
 9. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline,

protocol or other similar criterion will be provided free of charge on request;

10. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
11. In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification; and
12. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For complaints and general inquiries:

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

For external review requests:

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

Timing of Required Notices and Extensions

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

- a. **Urgent Care Clinical Claim** is any pre-service claim that requires Preauthorization, as described in this Certificate, as a prerequisite for receiving benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical

condition, would subject the claimant to severe pain that cannot be adequately managed without care or treatment.

- b. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
- c. **Post-Service Claim** is notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which Blue Cross and Blue Shield may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your claim is incomplete, Blue Cross and Blue Shield must notify you within:	24 hours**
If you are notified that your claim is incomplete, you must then provide completed Claim information to Blue Cross and Blue Shield within:	48 hours after receiving notice
<i>Blue Cross and Blue Shield must notify you of the claim determination (whether adverse or not):</i>	
if the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
after receiving the completed claim (if the initial claim is incomplete), within:	48 hours

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

** Notification may be oral unless the claimant requests written notification.

Pre-Service Claims

Type of Notice or Extension	Timing
If your claim is filed improperly, Blue Cross and Blue Shield must notify you within:	5 days*
If your claim is incomplete, Blue Cross and Blue Shield must notify you within:	15 days

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

* Notification may be oral unless the claimant requests written notification.

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

Post-Service Claims

Type of Notice or Extension	Timing
If your claim is incomplete, Blue Cross and Blue Shield must notify you within:	30 days
If you are notified that your claim is incomplete, you must then provide completed claim information to Blue Cross and Blue Shield within:	45 days after receiving notice
<i>Blue Cross and Blue Shield must notify you of the claim determination (whether adverse or not):</i>	
if the initial claim is complete, within:	30 days*
after receiving the completed claim (if the initial claim is incomplete), within:	45 days

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

Concurrent Care

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

INQUIRIES AND COMPLAINTS

An “**Inquiry**” is a general request for information regarding claims, benefits, or membership. A “**Complaint**” is an expression of dissatisfaction by you either orally or in writing.

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

- Claims
- Quality of care

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

To pursue an Inquiry or a Complaint, you may call **customer service** at the number on the back your ID card or you may write to:

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

When you contact customer service to pursue an Inquiry or Complaint, you will receive a written response to your Inquiry or Complaint within 30 days of receipt. Sometimes the acknowledgement and the response will be combined. If Blue Cross and Blue Shield needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

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

CLAIM APPEAL PROCEDURES

Claim Appeal Procedures — Definitions

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by Blue Cross and Blue Shield and Blue Cross and Blue Shield reduces or terminates such treatment (other than by amendment or termination of this Certificate)

before the end of the approved treatment period, which is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. Please refer to the provision entitled “RESCISSION” in the COVERAGE AND PREMIUM INFORMATION section of this Certificate for additional information.

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

1. A determination by Blue Cross and Blue Shield or its designee utilization review organization that, based upon the information provided, a request for a benefit under Blue Cross and Blue Shield’s health benefit plan upon application of any utilization review technique does not meet Blue Cross and Blue Shield’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;
2. The denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Blue Cross and Blue Shield or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or
3. A rescission of coverage. Please refer to the provision entitled “RESCISSION” in the COVERAGE AND PREMIUM INFORMATION section of this Certificate for additional information.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, Blue Cross and Blue Shield will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

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

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a review of any determination of a claim, any determination of a request for preauthorization, or any other determination made

by Blue Cross and Blue Shield in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care Provider may appeal on his/her own behalf. Under your Health Benefit Plan, there is one level of internal appeal available to you. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call Blue Cross and Blue Shield at the number on the back of your ID card.

In urgent care situations, a doctor may act as your authorized representative without completing the form.

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

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

Blue Cross and Blue Shield of Illinois
P.O. Box 3122
Naperville, IL 60566-9744
1-800-538-8833 Toll-free number
1-866-414-4258 Fax number
1-918-551-2011 Fax number for Urgent requests
send a secure email by using our message center by logging
into Blue Access for MembersSM (BAM) at www.bcbsil.com

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

Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on

appeal is made in order to give you a reasonable opportunity to respond. Blue Cross and Blue Shield may extend the time period described in this Certificate for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal will be conducted by individuals associated with Blue Cross and Blue Shield and/or by external advisors, but who were not involved in making the initial denial of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by Blue Cross and Blue Shield.

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

Blue Cross and Blue Shield will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 15 business days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 15 business days after we receive any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. If the appeal is related to administrative matters or Complaints, the Plan will render a decision of a pre-service or post-service appeal as soon as practical, but in no event more than 60 business days after receipt of all required information.

Notice of Appeal Determination

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

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
4. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil

action under Section 502(a) of ERISA following a final denial on external appeal. Specifically, this explanation will include:

- a. An explanation that if your case qualifies for external review, an Independent Review Organization will review your case (including any data you'd like to add);
- b. An explanation that you may ask for an external review with an Independent Review Organization (IRO) not associated with Blue Cross and Blue Shield if your appeal was denied based on any of the reasons below. You may also ask for external review if Blue Cross and Blue Shield failed to give you a timely decision (see d. below), and your claim was denied for one of these reasons:
 - A decision about the medical need for or the experimental status of a recommended treatment
 - A condition was considered pre-existing
 - Your health care coverage was rescinded

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

- c. An explanation that you may ask for an expedited (urgent) external review if:
 - Failure to get treatment in the time needed to complete an expedited appeal or an external review would seriously harm your life, health or ability to regain maximum function;
 - Blue Cross and Blue Shield failed to give you a decision within 48 hours of your request for an expedited appeal; or
 - The request for treatment is experimental or investigational and your health care Provider states in writing that the treatment would be much less effective if not promptly started; or
 - The Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility;
- d. Decisions on standard appeals are considered timely if Blue Cross and Blue Shield sends you a written decision for appeals that need medical review within 15 business days after we receive any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service. Decisions on expedited appeals are considered timely if Blue Cross and Blue

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

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

17. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For complaints and general inquiries:

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

For external review requests:

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

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

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

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

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

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

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

If You Need Assistance

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

Blue Cross and Blue Shield of Illinois
P.O. Box 3122
Naperville, Illinois 60566-9744
1-800-538-8833 Toll-free phone

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INDEPENDENT EXTERNAL REVIEW

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

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

a. Standard External Review

You or your authorized representative must submit a written request for a standard external independent review to the Illinois Department of Insurance (“IDOI”) within four months of receiving an Adverse Determination or Final Adverse Determination. Your request should be submitted to the IDOI at the following address:

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

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

1. **Preliminary Review.** Within five business days of receipt of the request from the IDOI, Blue Cross and Blue Shield will complete a preliminary review of your request to determine whether:
 - You were a covered person at the time health care service was requested or provided;
 - The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this Certificate, but Blue Cross and Blue Shield has determined that the health care service is not covered;
 - You have exhausted Blue Cross and Blue Shield’s internal appeal process, unless you are not required to exhaust Blue Cross and Blue Shield’s internal appeal process pursuant to the Illinois Health Carrier External Review Act; and
 - You have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Blue Cross and Blue Shield’s determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, your health care Provider has certified that one of the following situations is applicable:

- Standard health care services or treatments have not been effective in improving your condition;
- Standard health care services or treatments are not medically appropriate for you;
- There is no available standard health care services or treatment covered by Blue Cross and Blue Shield that is more beneficial than the recommended or requested service or treatment; or

In addition, a) your health care Provider has certified in writing that the health care service or treatment is likely to be more beneficial to you, in the opinion of your health care Provider, than any available standard health care services or treatments, or b) your health care Provider who is licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.

2. **Notification.** Within one business day after completion of the preliminary review, Blue Cross and Blue Shield shall notify the IDOI, you and your authorized representative, if applicable, in writing whether the request is

complete and eligible for an external review. If the request is not complete or not eligible for an external review, the IDOI, you and your authorized representative shall be notified by Blue Cross and Blue Shield in writing of what materials are required to make the request complete or the reason for its ineligibility. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, The IDOI's decision shall be in accordance with the terms of your benefit program (unless such terms are inconsistent with applicable laws) and shall be subject to all applicable laws.

3. **Assignment of IRO.** When the IDOI receives notice that your request is eligible for external review following the preliminary review, the IDOI will, within one business day after the receipt of the notice, a) assign an IRO on a random basis from those IROs approved by the IDOI; and (b) notify Blue Cross and Blue Shield, you and your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

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

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

4. **IRO's Decision.** In addition to the documents and information provided by Blue Cross and Blue Shield and you, or if applicable, your authorized

representative, the IRO shall also consider the following information if available and appropriate:

- Your pertinent medical records;
- Your health care Provider's recommendation;
- Consulting reports from appropriate health care Providers and other documents submitted to Blue Cross and Blue Shield or its designee utilization review organization, you, your authorized representative or your treating Provider;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield or its designated utilization review organization; and
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

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

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

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

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

The written notice will include:

- a. A general description of the reason for the request for external review;
- b. The date the IRO received the assignment from the IDOI;

- c. The time period during which the external review was conducted;
- d. References to the evidence or documentation including the evidence-based standards, considered in reaching its decision or in the case of external reviews of experimental or investigational services or treatments, the written opinion of each clinical reviewers as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
- e. The date of its decisions;
- f. The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and
- g. The rationale for its decision.

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

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

a. Expedited External Review

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination; (b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received Emergency Services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of a Final Adverse Determination or if Blue Cross and Blue Shield fails to provide a decision on a request for an expedited internal appeal within 48 hours.

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

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

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

Notification. Upon receipt of a request for an expedited external review, the IDOI shall immediately send a copy of the request to Blue Cross and Blue Shield. Blue Cross and Blue Shield shall immediately notify the IDOI, you and your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, IDOI's decision shall be in accordance with the terms of the benefit program (unless such terms are inconsistent with applicable law) and shall be subject to all applicable laws.

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

Upon receipt from the IDOI of the name of the IRO assigned to conduct the external review, Blue Cross and Blue Shield or its designated utilization review organization shall, immediately (but in no case more than 24 hours after receiving such notice) provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may submit additional information in writing to the assigned IRO within 24 hours or additional information may accompany the request for an expedited independent external review. If Blue Cross and Blue Shield or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the external review, the IRO shall notify the IDOI, Blue Cross and Blue Shield, you and, if applicable, your authorized representative, of its decision to reverse the determination.

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

If the external review was a review of experimental or investigational treatments, each clinical reviewer shall provide an opinion orally or in writing to the assigned IRO as expeditiously as our medical condition or circumstances requires, but in no event less than five calendar days after being selected. Within 48 hours after the date it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing to the IDOI,

Blue Cross and Blue Shield, you and your authorized representative, if applicable.

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

The assigned IRO is not bound by any decisions or conclusions reached during Blue Cross and Blue Shield's utilization review process or Blue Cross and Blue Shield's internal grievance appeal. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the Adverse Determination or Final Adverse Determination and not for additional services or supplies beyond the scope of the external review. If you disagree with the determination of the IRO, you may file a Complaint with the Illinois Department of Insurance's Office of Consumer Health Insurance.

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

GENERAL PROVISIONS

1. PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Plan has contracts with certain Providers (“Plan Providers”) in its service area to provide and pay for vision care services to all person entitled to vision care benefits under vision policies and contracts to which the Plan is a party, including all persons covered under this Certificate. Under certain circumstances described in its contract with Plan Providers, the Plan may:

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

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- a. Under this Certificate, the Plan has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. The Plan is specifically authorized by you to determine to whom any benefit payment should be made.
- b. Once Covered Services are rendered by a Provider, you have no right to request the Plan not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Plan will have no liability to you or any other person because of its rejection of such request.
- c. A Covered Person’s claim for benefits under this Certificate is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Certificate is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

- a. The choice of a Provider is solely your choice and the Plan will not interfere with your relationship with any Provider.
- b. The Plan does not itself undertake to furnish vision care services, but solely to make payments to Providers for Covered Services received by you. The Plan 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 Plan. Any contractual relationship between a Physician and a Plan Hospital or other Plan Provider shall not be construed to mean that the Plan is providing professional service.

- c. The use of an adjective such as Plan or Participating 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 Plan, Participating or any similar modifier or the use of a term such as Non-Plan 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 Group (other than as an individual Covered Person) or your Group's ERISA Health Benefit Program.

4. AGENCY RELATIONSHIPS

The Group is your agent under this Certificate. The Group is not the agent of the Plan.

5. DISCOUNTS

Discounts may be available, but are not insurance. Further, discounted prices may vary by state and are subject to change or discontinuance at any time without notice.

6. NOTICES

Any information or notice which you furnish to the Plan under this Certificate must be in writing and sent to the Plan at its offices at 300 East Randolph Street, Chicago, Illinois, 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which the Plan furnishes to you must be in writing and sent to you at your address as it appears on the Plan's records or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Plan's records. Blue Cross and Blue Shield may also provide such notices electronically, to the extent permitted by applicable law.

7. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate until at least sixty (60) days have elapsed since a Claim has been furnished to the Plan in accordance with the requirements of this Certificate. In addition, no such action may be brought once three (3) years have elapsed from the date that a Claim is required to be furnished to the Plan in accordance with the requirements of this Certificate.

8. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Certificate, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnification on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Plan or its agent, and agrees that any such Provider, person, or other entity may furnish to the Plan 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 Plan may furnish similar information and records (or copies of records) to Providers, other Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Plan and/or your Employer or group administrator information regarding you or your dependents becoming eligible for Medicare, termination of Medicare eligibility, or any change in Medicare eligibility status, in order that the Plan be able to make Claim Payments in accordance with MSP laws.

9. VALUE BASED DESIGN PROGRAMS

The Plan has the right to offer medical management programs, quality improvement programs, a health behavior wellness, maintenance, or improvement programs that allow for a reward, a contribution, a penalty, a differential in premiums, a differential in medical, prescription drug or equipment Copayments, Coinsurance, deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by the Plan or an entity chosen by the Plan to administer such programs. In addition, discount programs for various health and wellness-related or insurance-related items and services may be available from time to time. Such programs may be discontinued with or without notice.

Members unable to participate in these incentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, the Plan will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Contact the Plan for additional information regarding any value based programs offered by the Plan.

The Plan makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by the Plan

designated outside vendor and acceptance or declination of these services is optional to Member. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbsil.com or telephonically by calling the toll free telephone number on your identification card. Services may automatically end when the person is no longer an eligible member. Services may change or be discontinued at any time with or without notice and the Plan does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this benefit program.

Contact your Employer for additional information regarding any value based program offered by your Employer.

10. TIME LIMIT ON CERTAIN DEFENSES

After 2 years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by the applicant in the application for such Certificate shall be used to void the Certificate or to deny a claim for illness or injury beginning after the expiration of such 2 year period.

11. CONFORMITY WITH STATE STATUTES

This Certificate provides at a minimum, coverage as required by Illinois law. Laws in some other states require that certain benefits or provisions be provided to you if you are a resident of their state when the policy that insures you is not issued in your state. In the event any provision of this Certificate, on its effective date, conflicts with the laws of the state in which you permanently reside, you will be provided the greater of the benefit under this Certificate or that required under the laws of the state in which you permanently reside.

12. ENTIRE CONTRACT

The Group Contract, including the agreement between the Plan and the Group, any addenda, this Certificate, the Group's application to the Exchange and Plan, as appropriate, along with any exhibits, appendices, addenda and/or other required information and the individual application(s) of the persons covered under the Policy, benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Group Policy, to extend the time for payment of premiums, or to waive any of the rights or requirements of the Plan. No modifications of the Group Policy will be valid unless evidenced by an endorsement or amendment of the Group Policy, signed by an officer of the Plan and delivered to the Group.



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

Effective Date: September 1, 2022

www.bcbsil.com

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