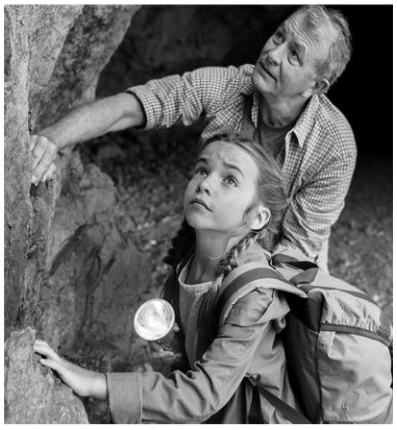
BMO

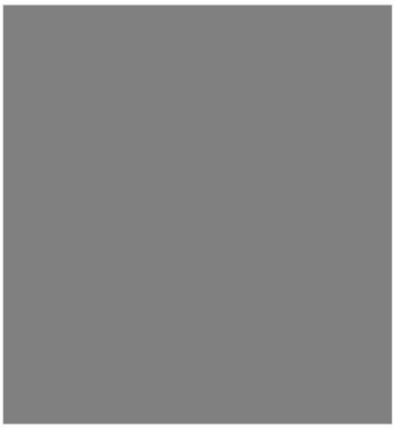
# Blue Cross Blue Shield of Illinois Summary Plan Description (SPD)

Employee Benefit Program of Bank of Montreal/Harris

Administered by:

BlueCross BlueShield of Illinois






# Your Health Care Benefits Program

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

BMO Financial Corp

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A message from

## BMO Financial Corp

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. BMO Financial Corp. intends to continue the Plan, but reserves the rights, in its sole discretion, to modify, change revise, amend or terminate the Plan at any time, for any reason, and without prior notice. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary. If you want more information or have any questions about your health care benefits, please contact the number on the back of your ID card or the Human Resources Centre at 1-888-927-7700.

Sincerely,

BMO Financial Corp

## 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.**

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

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to the Plan's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the Plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your Identification Card.

# Table of Contents

## BENEFIT HIGHLIGHTS

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

| | |
|---|---|
| UTILIZATION MANAGEMENT AND REVIEW | A special program designed to assist you in determining the course of treatment that will maximize your benefits described in this benefit booklet |
| Lifetime Maximum for all Benefits | Unlimited |

The state of Utah's definition of what is an "essential health benefit" shall be the controlling definition used by the Plan in determining whether a particular benefit is an essential health benefit for purposes of compliance with the Patient Protection and Affordable Care Act.

| | |
|---|---|
| Individual Coverage Deductible** | |
| — Participating Provider | $1,750 per benefit period |
| — Non-Participating and Non-Administrator Provider | $3,500 per benefit period |
| Family Coverage Deductible** | |
| — Participating Provider | $3,500 per benefit period |
| — Non-Participating and Non-Administrator Provider | $7,000 per benefit period |
| Individual Coverage Out-of-Pocket Expense Limit** | |
| — Participating Provider | $3,425 per benefit period |
| — Non-Participating Provider | $6,850 per benefit period |
| — Non-Administrator Provider | No limit |
| Family Coverage Out-of-Pocket Expense Limit** | |
| — Participating Provider | $6,850 per benefit period |
| — Non-Participating Provider | $13,700 per benefit period |
| — Non-Administrator Provider | No limit |
| Private Duty Nursing Service Benefit Maximum | 60 visits per benefit period |
| Chiropractic and Osteopathic Manipulation Benefit Maximum | 20 visits per benefit period |
| Naprapathic Services Benefit Maximum | 20 visits per benefit period |
| Physical, Occupational, and Speech Therapies Combined Benefit Maximum*** | 60 visits per benefit period |

| | |
|---|---|
| HOSPITAL BENEFITS | |
| Payment level for Covered Services from a **Participating Provider:** | |
| — Inpatient Covered Services | 80% of the Eligible Charge |
| — Outpatient Covered Services | 80% of the Eligible Charge |
| Payment level for Covered Services from a **Non-Participating Provider:** | |
| — Inpatient Covered Services | 60% of the Eligible Charge |
| — Outpatient Covered Services | 60% of the Eligible Charge |
| Payment level for Covered Services from a **Non-Administrator Provider** | 60% of the Non-Participating Hospital Benefit Payment Level |
| Hospital Emergency Care | |
| — Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider | 80% of the Eligible Charge |
| — Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider | 80% of the Eligible Charge |
| Emergency Room | $100 Copayment (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment) |
| PHYSICIAN BENEFITS | |
| Payment level for Surgical/ Medical Covered Services After you meet the Annual Deductible | |
| — **Participating Provider** | 80% of the Maximum Allowance |
| — **Non-Participating Provider** | 60% of the Maximum Allowance |
| Payment level for Emergency Accident Care | 80% of the Maximum Allowance |

| | |
|---|---|
| Payment level for Emergency Medical Care | 80% of the Maximum Allowance |

OTHER COVERED SERVICES

| | |
|---|---|
| Payment level | 80% of the Eligible Charge or Maximum Allowance |

**BLUE DISTINCTION CENTERS (BDC) &**
**BLUE DISTINCTION CENTERS PLUS (BDC+)**
**BENEFIT DIFFERENTIAL**

***(YOUR PROGRAM DEDUCTIBLE APPLIES TO THE BELOW BENEFITS, UNLESS OTHERWISE SPECIFIED.)***

Payment level for Transplants

| | |
|---|---|
| — BDC+ Designated Center | 80% of the Eligible Charge |
| — BDC Designated Center | 80% of the Eligible Charge |
| — Participating Provider | 60% of the Eligible Charge |
| — Non-Participating Provider | 60% of the Eligible Charge |

HEARING BENEFITS

| | |
|---|---|
| Benefit Payment Level | 100% after Deductible of the U&C Fee* |
| Hearing Aids Lifetime Maximum | $5,000 |

***BENEFITS FOR AUTISM SPECTRUM DISORDER(S) WILL NOT APPLY TOWARDS AND ARE NOT SUBJECT TO ANY PHYSICAL, SPEECH OR OCCUPATIONAL THERAPY VISITS MAXIMUM.

**TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.**

*Usual and Customary Fee

***Should the Federal Government adjust the Deductible for High Deductible Plans as defined by the Internal Revenue Service, the Deductible amount in this benefit booklet will be adjusted accordingly.

## DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

A1C TESTING....means blood sugar level testing used to diagnose prediabetes, type I diabetes, and type II diabetes, and to monitor management of blood sugar levels.

ACUPUNCTURIST.....means a duly licensed acupuncturist operating within the scope of his or her license.

ACUTE TREATMENT SERVICES.....means a 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist operating within the scope of his or her certification.

AMBULANCE TRANSPORTATION.....means local transportation in specially equipped certified ground and air ambulance options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this health care plan.

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE.....means i) for ambulance providers that bill for Ambulance Transportation services through a Participating Hospital the Ambulance Transportation Eligible Charge is the applicable ADP, and ii) for all other ambulance providers, the Ambulance Transportation Eligible Charge is such provider’s Billed Charge.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis, and which is duly licensed by the appropriate state and local authority to provide such services.

An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

(ii) A clinical trial conducted under an FDA experimental/investigational new drug application, or

(iii) A drug that is exempt from the requirement of an FDA experimental/investigational new drug application.

AUDIOLOGIST.....means a duly licensed Audiologist operating within the scope of his or her license.

A "Participating Audiologist" means an Audiologist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time Covered Services are rendered.

A "Non-Participating Audiologist" means an Audiologist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Covered Services to you at the time Covered Services are rendered.

AUTISM SPECTRUM DISORDER(S).....means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

AVERAGE DISCOUNT PERCENTAGE ("ADP").....means a percentage discount determined by the Claim Administrator that will be applied to a Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding "Claim Administrator's

Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness or Substance Use Disorders and is operating within the scope of such license.

BEHAVIORAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Treatment benefits, including Prior Authorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Use Disorder.

BILLED CHARGES.....means the total gross amounts billed by Providers to the Claim Administrator on a Claim, which constitutes the usual retail price that the Provider utilizes to bill patients or any other party that may be responsible for payment of the services rendered without regard to any payer, discount or reimbursement arrangement that may be applicable to any particular patient. This list of retail prices is also sometimes described in the health care industry as a "chargemaster."

BIOMARKER TESTING.....means the analysis of tissue, blood, or fluid biospecimen for the presence of a biomarker, including, but not limited to singly-analyte tests, multi-plex panel tests, and partial or whole genome sequencing.

BLUE DISTINCTION CENTERS (BDC).....means a health care Provider, Hospital, or medical facility recognized for their expertise in delivering specialty care. Please see the section entitled "Blue Distinction Centers" for more information.

BLUE DISTINCTION CENTERS+ (BDC+).....means a health care Provider, Hospital, or medical facility recognized for their expertise and efficiency in delivering specialty care. Please see the section entitled "Blue Distinction Centers" for more information.

BLUE DISTINCTION CENTERS (BDC) and BLUE DISTINCTION CENTERS+ (BDC+) BENEFIT DIFFERENTIAL PRODUCT.....means your employer has chosen to provide a lower out-of-pocket cost when you utilize a BDC or BDC+ designated provider for certain specialty care procedures and treatment.

CARE COORDINATION.....means organized, information-driven patient care activities intended to facilitate the appropriate responses to participant's health care needs cross the continuum of care.

CARE COORDINATION FEE.....means a fixed amount paid by a Blue Cross and/or Blue Shield plan to Providers.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of an advanced practice nursing program.

A "Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A "Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of an advanced practice nursing program.

A "Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse and is operating within the scope of such license; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A "Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

CHIROPRACTOR.....means a duly licensed chiropractor and is operating within the scope of his or her license.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

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

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A "Participating Clinical Laboratory" means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor operating within the scope of his or her license.

A "Participating Clinical Professional Counselor" means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Professional Counselor" means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker operating within the scope of his or her license.

A "Participating Clinical Social Worker" means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Social Worker" means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL STABILIZATION SERVICES.....means a 24-hour treatment, usually following acute treatment services for Substance Use Disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

CLINICIAN.....means a person operating within the scope of his/her license, registration or certification in the clinical practice or medicine, psychiatry, psychology, or behavior analysis.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

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

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

CONGENITAL OR GENETIC DISORDER.....means a disorder that includes, but is not limited to, hereditary disorders. Congenital or Genetic Disorders may also include, but is not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

CONTRACTED PROVIDER.....means a Participating Provider and a Participating Professional Provider, collectively.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician, a Physician Assistant who has been authorized by a Physician to prescribe those services, or an advanced practice nurse with a collaborating agreement with a Physician that delegates that authority. This program includes physical, occupational and speech therapists and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service or Custodial Care Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An "Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A "Non-Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

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

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

(i) A group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

(iv) Medicaid (Title XIX of the Social Security Act).

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.

(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

(x) A health plan under Section 5(e) of the Peace Corps Act.

(xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (including but not limited to dressings, administration of routine medications, ventilator suctioning and other care) and are to assist with activities of daily living (including but not limited to bathing, eating and dressing).

DEDUCTIBLE.....means the amount of expense that you must incur in Covered Services before benefits are provided.

DENTIST.....means a duly licensed dentist operating within the scope of his or her license.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease, or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans, positron emission tomography (PET) scans.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services, when operating within the scope of such license.

An "Administrator Dialysis Facility" means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Dialysis Facility" means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of at least a year with indefinite duration with a person of the same or opposite sex which meets the following criteria:

- you share a sole, committed relationship with each other that has existed for at least one year and is expected to last indefinitely;
- you are jointly responsible for each other's welfare and financial obligations;
- you share your principal place of residence;
- you are both at least 18 years old and mentally competent to consent to a contract;
- neither of you is married to, legally separated from or in another domestic partner relationship with anyone else; and
- you are not related to each other in a way that would prohibit a legal marriage from being recognized in the state in which you live.

The following documentation that demonstrates you meet the eligibility requirements is required. Two of the items listed must be provided, however, additional documentation may be requested if necessary to determine eligibility.

- Federal and State Tax Returns
- Domestic Partnership Agreement
- Joint mortgage, lease or ownership of real estate property
- Primary beneficiary designation for will, life insurance and/or retirement benefits
- Assignment of durable power of attorney
- Joint ownership of motor vehicle or investments
- Joint checking or credit account
- Joint responsibility for debts
- Other document stating common residency

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider, when operating within the scope of such license.

A "Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to covered persons in the benefit program or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services for medical benefits are rendered by a Participating Provider, such Participating Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services for medical benefits are rendered ("Non-Participating Provider"), the following amount (unless otherwise required by applicable law or arrangement with the Non-Participating Provider):

(i) the lesser of (a) the Provider's Billed Charges, and (b) an amount determined by the Claim Administrator to be approximately 150% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (a) the Provider's Billed Charges and (b) an amount determined by the Claim Administrator to be 150% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the Eligible Charge cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 150% of the Provider's Billed Charges, provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to the covered person.

The Claim Administrator will utilize the same Claim processing rules, edits, or methodologies that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the non-contracting Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits, rules or methodologies, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The non-contracting Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Eligible Charge amount does not equate to the Non-Participating Provider's Claim Charge, you will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance, and deductible amount(s).

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

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services. The initial Outpatient treatment does not include surgical procedures, including but not limited to, stitching, gluing, and casting.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions, or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorders condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMPLOYER or COMPANY.....means the company with which you are employed and which sponsors this Plan.

ENROLLMENT DATE.....means the first day of coverage under your Employer's health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL or EXPERIMENTAL/INVESTIGA TIONAL SERVICES AND SUPPLIES.....means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment for the condition being treated or, if any of such items required federal or other governmental agency approval, such approval was 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, mental health treatment, Substance Use Disorder Treatment, 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 Claim Administrator 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-fixed programs in making its determination.

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

Approval by a government or regulatory agency will be taken into consideration in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

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

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider, when operating within the scope of such license.

A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service, when operating within the scope of such license.

A "Participating Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

A "Non-Participating Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has not been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility, or special hospice care unit.

HOSPITAL.....means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for your-self but not your spouse and/or dependents.

INFUSION THERAPY.....means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INTENSIVE OUTPATIENT PROGRAM.....means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder. Requirements: the Claims Administrator requires that any Mental Illness and/or Substance Use Disorder Intensive Outpatient Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by the Claims Administrator, as set forth in the current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute Inpatient, residential care or a Partial Hospitalization Treatment Program.

LIFE-THREATENING DISEASE OR CONDITION.....means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury, or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist operating within the scope of his or her license.

A "Participating Marriage and Family Therapist" means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service, or the reimbursement amount set by the Claim Administrator, or the Host Blue Plan for Providers designated as Participating Professional Providers for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Provider will be based on the Schedule of Maximum Allowances which such Provider has agreed to accept as payment in full (b) for Non-Participating Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with Non-Participating Providers):

(i) the Provider's Billed Charges, or;

(ii) the Claim Administrator's non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 150% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim. Notwithstanding the preceding sentence, (1) the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's Billed Charges for such Covered Services, (2) the non-contracting Maximum Allowance for Ambulance Transportation services provided by Providers (other than Providers that bill through a Participating Provider, which use "Eligible Charge") will be such provider's Billed Charge, as described in the definition of Ambulance Transportation Eligible Charge, and (3) the non-contracting Maximum Allowance for other unsolicited Providers will be the same as the Maximum Allowance described in (a) above.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined based on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 100% of the Claim Administrator's rate for such Covered Services according to its current Schedule of Maximum Allowances. If there is no rate according to the Schedule of Maximum Allowances, then the Maximum Allowance will be 25% of Claim Charges.

The Claim Administrator will utilize the same Claim processing rules, edits, or methodologies that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the non-contracting Maximum Allowance for a particular Covered Service. In the event the Claim Administrator does not have any Claim edits, rules or methodologies, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such Claims. The non-contracting Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Maximum Allowance amount does not equate to the Non-Participating Professional Provider's Claim Charge, you will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance, and deductible amount(s).

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

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY/MEDICAL NECESSITY.....means that a specific medical, health care, supply or Hospital service is required for the treatment or management of a medical symptom or condition, and that the service, supply or care provided is the most efficient and economical service which can safely be provided.

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary, does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies. Please refer to the *Exclusions – What Is Not Covered* section of this booklet for additional information.

The Claim Administrator will make the initial decision whether hospitalization or other health care services or supplies were not Medically Necessary. In most instances this initial decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED. In making decisions of whether the hospitalization or other health care service(s) or supply(ies) are not Medically Necessary, and therefore not eligible for payment under the terms of this Plan, the Claim Administrator will take into account the information submitted to the Claim Administrator by your Provider(s), including any consultations with such Providers(s).

Hospitalization or other health care is not Medically Necessary when, applying the definition of Medical Necessary to the circumstances surrounding the hospitalization or other health care, it is determined that the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital, or some other setting without adversely affecting the patient's condition.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's initial decision, your benefit program provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against the Claim Administrator, either at law or in equity. To initiate your appeal, you must give the Claim Administrator written notice of your intention to do so as described in the *Claim Filing and Appeals Procedures* section of this booklet.

Below are some examples, not an exhaustive list, of hospitalization or other health care services and supplies that are not Medically Necessary:

1. Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
2. Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.

3. Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
4. Hospitalization or admission to a Skilled Nursing Facility or Residential Treatment Center, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
5. The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

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

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

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 implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL ILLNESS.....means a condition or disorder that involves a mental health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

NAPRAPATH.....means a duly licensed Naprapath operating within the scope of such license.

A "Participyating Naprapath" means a Naprapath who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Naprapath" means a Naprapath who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-EMERGENCY FIXED-WING AMBULANCE TRANSPORTATION.....means Ambulance Transportation on a fixed-wing airplane from a Hospital emergency department, other health care facility or Inpatient setting to an equivalent or higher level of acuity facility when transportation is not needed due to an emergency situation. Non-Emergency Fixed-Wing Ambulance Transportation may be considered Medically Necessary when you require acute Inpatient care and services are not available at the originating facility and commercial air transport or safe discharge cannot occur. Non-Emergency Fixed-Wing Ambulance Transportation provided

primarily for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this Health Care Plan.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist operating within the scope of his or her license.

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

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

A "Participating Optometrist" means an Optometrist who has a written agreement with the Claim Administrator or 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 the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider operating within the scope of his or her license.

A "Participating Orthotic Provider" means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Orthotic Provider" means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

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

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment in which patients spend days or nights. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an Inpatient unit, i.e., medically supervised by a Physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Participants at this level of care do not require 24-hour supervision and are not considered a resident at the program.

Requirements: The Claim Administrator requires that any Mental Illness and/or Substance Use Disorder Partial Hospitalization Treatment Program must be licensed in the state where it is located or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

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

PHARMACY.....means a state and federally licensed establishment that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he/she practices.

PHYSICAL THERAPIST.....means a duly licensed physical therapist operating within the scope of his or her license.

PHYSICAL THERAPY.....means the treatment of a disease, injury, or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

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

PHYSICIAN ASSISTANT.....means a duly licensed Physician Assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of his or her license.

PODIATRIST.....means a duly licensed podiatrist operating within the scope of his or her license.

PRIOR AUTHORIZATION.....means a requirement that you must obtain authorization from the Claim Administrator before you receive certain types of Covered Services designated by the Claim Administrator.

PRIOR AUTHORIZATION or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Behavioral Health Unit for a determination of Medically Necessary care under this benefit booklet.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider operating within the scope of his or her license.

A "Participating Prosthetic Provider" means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Prosthetic Provider" means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you and operating within the scope of such license.

An "Administrator Provider" means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Provider" means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A "Participating Provider" means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A "Non-Participating Provider" means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A "Professional Provider" means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

PROVIDER INCENTIVE.....means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed upon procedural and/or outcome measures for a particular population of participants.

PSYCHOLOGIST.....means a Registered Clinical Psychologist operating within the scope of such license.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois "Psychologists Registration Act" or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

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

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

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

QUALIFIED ABA PROVIDER.....means a Provider operating within the scope of his/her license registration or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:

(i) Master's level, independently licensed Clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided, for services treating Autism Spectrum Disorder (ASD) symptoms, with or without applied behavior analysis (ABA) service techniques; or

(ii) Master's level Clinician whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e. Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst-Doctoral (BCBA-D), to supervise and provide treatment planning, with ABA services techniques; or

(iii) Health Care Practitioner who is certified as a provider under the TRICARE military health system, if requesting to provide ABA services; or

(iv) Master's level Clinician with a specific professional credential or certification recognized by the state in which the clinician is located; or

1. Developmental Therapist with Certified Early Intervention Specialist credential or CEIS; or
2. If the Doctor or Medicine (MD) prescribes ABA, writes a MD order for services to be provided by a specific person.

For the para-professional/line therapist:

(i) Two years of college educated staff person with a Board Certified Assistant Behavior Analyst (BCABA) for the para-professional/therapist; or

(ii) A bachelor level or high school graduate having obtained a GED, OR a staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist; or

(iii) A person who is "certified as a provider under TRICARE military health system," if requesting to provide ABA services.

RECOMMENDED CLINICAL REVIEW.....means an optional voluntary review of Provider's recommended medical procedure, treatment, or test, that does not require Prior Authorization, to make sure it meets approved Claim Administrator medical policy guidelines and Medical Necessity requirements.

REGISTERED DIETICIAN.....means a duly licensed clinical professional counselor operating within the scope of his or her license.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of his or her certification.

A "Participating Registered Surgical Assistant" means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Registered Surgical Assistant" means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESCISSION.....means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and 24-hour on site nursing service for patients with Mental Illness and/or Substance Use Disorders. Any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

RESPITE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

A "Participating Retail Health Clinic" means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Retail Health Clinic" means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ROUTINE PATIENT COSTS.....means the cost for all items and services consistent with the coverage provided under this benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

(i) The investigational item, device, or service, itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services and operating within the scope of such license.

An "Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST.....means a duly licensed speech therapist operating within the scope of his or her license.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy

does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE USE DISORDER.....means a condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

SUBSTANCE USE DISORDER TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disabilities or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such license. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An "Administrator Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility that does not meet the definition of an Administrator Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations, and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOBACCO USER.....means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your Identification Card or visit our website at *www.bcbsil.com*.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

TRANSPLANT LODGING ELIGIBLE EXPENSE.....means the amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

VALUE BASED PROGRAM.....means an out-come based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

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

VIRTUAL VISIT.....means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the VIRTUAL VISITS provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

VITAMIN D TESTING....means vitamin D blood testing that measures the level of vitamin D in a person’s blood.

## ELIGIBILITY SECTION

This benefit booklet contains information about the health care benefit program for the persons who:

- Meet the following definition of an Eligible Person: Full-time employee or part-time employee who is scheduled to work at least 20 hours per week.

You are considered an "employee" only if you are specifically treated or classified as an employee on Company records for purposes of withholding federal employment and income taxes. If the Company classifies you as an independent contractor, consultant, leased employee or similar type of non-employee, you are specifically excluded from participating in the Plan, even if a court, the Internal Revenue Service or another agency retroactively reclassifies you as an employee.

If you meet this description and comply with the other terms and conditions of this benefit booklet, including but not limited to payment of premiums, you are entitled to the benefits of this program.

### MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the ELIGIBILITY Section above and you are eligible for Medicare and not affected by the "Medicare Secondary Payer" (MSP) laws as described below, the benefits described in the section of this benefit booklet entitled "Benefits for Medicare Eligible Covered Persons" will apply to you and to your spouse and covered dependent children (if he or she is also eligible for Medicare and not affected by the MSP law). This section does not apply to a Domestic Partner of the Eligible Person and their children.

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.

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."
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."

**PLEASE NOTE: SEE YOUR EMPLOYER SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY 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 Claim Administrator 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 promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

**If you are actively working and qualify for Medicare, you are not required to enroll for Medicare coverage. Your Company Medical Plan continues as your primary coverage.**

## YOUR ID CARD

You will receive an Identification Card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

## INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

## FAMILY COVERAGE

If you elect Family Coverage, you may enroll your eligible dependents, which include:

- your legal spouse, unless you are legally separated or divorced. A legal spouse includes a same-sex or opposite-sex individual who is recognized as your spouse for purposes of federal tax laws (a common-law spouse is eligible if you legally establish the marriage in a state that recognizes common-law marriages and is recognized as your spouse for purposes of federal tax laws);
- your qualifying same-sex or opposite-sex domestic partner if your relationship satisfies certain criteria (see *definition of Domestic Partnership*); and
- your children under age 26.

Child(ren) used hereafter, means:

- your biological children;
- your adopted children or children placed with you for adoption;
- your stepchildren, regardless of where they live (includes stepchildren from your same-sex or opposite-sex legal spouse);
- foster children living with you;
- a child who is recognized under a qualified medical child support order as having a right to health care coverage, if the child meets the other eligibility requirements of the Plan for dependent coverage;
- any other child for whom you are the legal guardian and whom you support in a parent-child relationship; and
- your domestic partner's children if they qualify as your dependents for income tax purposes according to Section 152 of the Internal Revenue Code.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship).

If you have Family Coverage, your health expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled children up to age 26 will be covered. The coverage for children will end on the last day of the month in which the limiting age is reached.

Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions of this benefit booklet that pertain to a spouse also apply to a Domestic Partner, unless specifically noted otherwise.

Any newborn children will be covered from the moment of birth, as long as you have taken the appropriate steps to enroll them in coverage by submitting a qualified life event in Workday or notifying BMO Human Resources Centre within 90 days of the date of birth.

## EXTENDED COVERAGE FOR DISABLED CHILDREN

If you have an adult dependent child age 26 or over that is physically or mentally incapable of self-support, the child may continue to be eligible to be covered on your BMO Plan if certain conditions are met.

The Plan will cover the adult dependent child, as long as:

- the child is unmarried;
- the child is unable to be self-supporting due to a disabling condition;
- the child depends mainly on you for support;
- the child is considered your tax dependent;
- the child's disability existed prior to the child reaching age 26;
- you provide proof of the child's disability and dependency within 31 days of the date coverage would have otherwise ended because the child reached age 26; and
- you provide proof, upon request by the Plan, that the child continues to meet these conditions.

The proof may include medical records, determination of disability, and copies of your Federal tax returns. If you do not supply the required documentation within 31 days of the child's 26th birthday or when requested, the child will not be eligible for benefits under the Plan.

Coverage will continue, as long as the enrolled adult dependent child continues to meet the conditions above, unless coverage is otherwise terminated in accordance with the terms of the Plan. You may also need to provide proof of continued disability from time to time to maintain coverage.

## NON-DUPLICATION OF COVERAGE

Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this plan.

If you and your spouse or domestic partner are both BMO employees and eligible to enroll in the Plan, you may each enroll for individual coverage or one of you may enroll and cover the other. If you each enroll for individual coverage, only one of you may enroll your children as dependents.

If you and your child(ren) (under age 26) are both BMO employees and eligible to enroll in the Plan, you may each enroll for individual coverage or the parent can cover the child(ren) under their plan.

## QUALIFED MEDICAL CHILD SUPPORT ORDER

A qualified medical child support order (QMCSO) is a legal judgment, decree or order issued under a state domestic relations law by a court or an administrator. A QMCSO recognizes the rights of a child to coverage for health care benefits. Under a medical child support order, the court or an administrative agency can require you to provide coverage to a child under the Medical, Dental or Vision Plans.

BMO will comply with the requirements for coverage outlined in a QMSCO. If BMO is notified that any of your children are covered by a QMSCO, you will be required to remain enrolled in BMO's medical, dental or vision plans, covering the applicable children, until the QMSCO is no longer valid. You may call the Human Resources Centre at 1-888-927-7700 for information regarding the procedures governing QMCSOs.

## DOMESTIC PARTNER'S CHILDREN

If your domestic partner meets the requirements, then his or her children may also be considered eligible dependents under the Plan. Children of domestic partners are subject to the same eligibility requirements that biological and adopted children must meet. You can enroll your domestic partner's children only if they qualify as your legal tax dependents. As a result, premiums for coverage of all dependent children are made on a pretax basis with no imputed income.

## QUALIFYING FOR TAX DEPENDENT STATUS

To qualify as a tax dependent, your domestic partner or domestic partner's children must meet the rules under Section 152 of the Internal Revenue Code. In addition, tax dependents must be claimed on your federal tax return. If your domestic partner qualifies under Code Section 152, he or she may enroll as a tax dependent. Otherwise, your domestic partner may enroll as a non-tax dependent. You can enroll your domestic partner's children only if they qualify as your legal tax dependents.

If your domestic partner meets the Domestic Partner eligibility requirements, he or she can enroll as either a tax dependent or a non-tax dependent. The following chart summarizes the differences between tax dependent and non-tax dependent status.

| Two Options for Domestic Partner Status | | |
|---|---|---|
| | **Tax Dependent Status** | **Non-Tax Dependent Status** |
| **Who Qualifies** | Domestic partner who satisfies the requirements listed above and is your legal dependent for tax purposes as defined under Internal Revenue Code Section 152.Domestic partner's children if they meet eligibility requirements and qualify as your tax dependents. | Domestic partner who satisfies the requirements listed above but is not your legal dependent for tax purposes.<br><br>Domestic partner's children are not eligible for coverage if they are non-tax dependents. |
| **How Premiums Are Deducted** | Domestic partner's portion of the premium is deducted from your pay before taxes, just like your own premium. | Domestic partner's portion of the premium is deducted from your pay after taxes. |
| **Tax Impact** | You are not taxed on the Company's contribution toward your domestic partner's premium. | The Company's contribution toward your domestic partner's premium is considered additional imputed income, which is taxable to you on your paycheck when deductions are taken. |
| **Impact on Spending Accounts** | Your domestic partner's (and/or their qualifying children's) eligible medical expenses may be eligible under your Health Care Spending Account or Health Savings Account. | None of your domestic partner's expenses are eligible. |
| | | |

**IMPUTED INCOME**

The additional premium for enrolling a domestic partner is equal to that for a spouse. Similarly, children of domestic partners are subject to the same premium rates as biological or adopted children.

For tax dependent domestic partners and their eligible children, the additional premium is deducted from your pay on a pretax basis. For non-tax dependent domestic partners, the additional premium is deducted from your pay after taxes, and the BMO paid portion of the premium appears on your pay stub as additional taxable income ("imputed" income). If you reside in a state that recognizes civil unions, you may be able to take a tax deduction for post-tax premiums paid when filing your state taxes. Consult with a tax advisor for more information.

## CERTIFICATION

When you enroll your domestic partner, you'll be asked to certify that your domestic partner meets the eligibility requirements. You'll also be asked to certify whether your domestic partner qualifies as a tax dependent. The Company assumes all employees will be truthful in making representations about both eligibility and tax status. While you won't be asked to provide proof of these mattes when you enroll, the Company reserves the right to request proper documentation at its discretion.

## VERIFYING DEPENDENTS

As a contingency for coverage under the Plan, you must submit documentation to demonstrate that all your covered dependents meet the Plan's eligibility criteria. You will need to submit the required documentation to Dependent Verification Services for all dependents you are covering on your medical, dental and/or vision plans. You must also provide documentation to demonstrate any other matters requested by the Plan (not just for verifying dependents). Shortly after you choose to enroll your dependent(s) on your medical, dental and/or vision plans for the first time, you will be contacted by Dependent Verification Services to complete the verification process. If you do not complete the verification process within the allotted timeframe, any unverified dependents will be removed from your coverage effective the 1st of the month following the date your final determination letter is sent from Dependent Verification Services. Failure of the dependent verification process is not a qualifying event, and COBRA will not be offered.

Periodically the Plan will conduct follow-up verifications of all covered dependents to ensure ongoing eligibility for the Plan.

The documentation that is required to verify your dependents includes:

| Dependent Type | Required Documentation Category 1 | Required Documentation Category 2 |
|---|---|---|
| **Spouse** (1 document from each category required) | • Government issued Marriage Certificate; or<br>• Notarized Affidavit of common law marriage | • Joint Federal tax return filed within prior 2 years; or<br>• Proof of joint ownership within last 6 months |
| **Domestic Partner** | • Certificate of Domestic Partner registration; or | • Joint tax return filed within prior 2 years; or |

| Dependent Type | Required Documentation Category 1 | Required Documentation Category 2 |
|---|---|---|
| (1 document from each category required) | • Notarized Affidavit of Domestic Partnership; or<br>• Government issued certificate of Civil Union Partnership | • Proof of joint ownership within last 6 months |
| **Biological Child** (1 document from category 1 required) | • Government issued Birth certificate including parent's names | |
| **Adopted Child** (1 document from category 1 required) | • Government issued Birth certificate; or<br>• Adoption Certificate; or<br>• Placement Agreement | |
| **Step-Child** (documents from both categories required) | • Government issued Birth certificate including parent's names | • Verification of parent's spouse relationship status to the employee (must satisfy documentation requirements for spouse) |
| **Domestic Partner's Child** (documents from both categories required) | • Government issued Birth certificate including parent's names | • Verification of parent's partner relationship status to the employee (must satisfy documentation requirements for Domestic Partner) |
| **Legal Ward** (documents from both categories required) | • Government issued Birth certificate including parent's names | • Court ordered document of legal guardianship |
| **Grandchild** (All documents from both categories required) | • Grandchild's Government issued Birth certificate including parent's names; and<br>• Biological parent' s Government issued Birth certificate including parent's names | • Federal tax return filed within prior 2 years claiming grandchild as tax dependent |
| **Foster Child** (documents from both categories required) | • Government issued Birth certificate | • Foster care letter of placement |

| Dependent Type | Required Documentation Category 1 | Required Documentation Category 2 |
|---|---|---|
| **Disabled Adult Child** (All documents from both categories required) | • Documentation listed above to prove child relationship status; and<br>• Proof of disability document | • Federal tax return filed within prior 2 years claiming disabled adult child as tax dependent |

## ENROLLING & CHANGES

### HOW TO ENROLL

Coverage under the Plan is not automatic; you must enroll, go to **Workday**, click on the **My Benefits & Retirement** application. As a new employee or an employee who changes to benefit-eligible status, you have 31 calendar days (includes your date of hire*/ newly benefit-eligible date) to make your benefit elections. Coverage begins on the first day of the month following 30 days from your date of hire or change in benefit eligible status date if you enroll within this 31-day period.

*The benefit effective date for employees hired as part of an acquisition and/or merger may be different based upon the terms of the purchase agreement.

Once made, you generally cannot change your elections during the year. If you miss the 31-day deadline and want to enroll in the Plan during the year, you can do so only in limited situations, for example, if you experience a qualifying life event or special enrollment event (see Qualifying Life Event and Special Enrollment for more information). If you have a qualifying life event or special enrollment event, you have 31 calendar days from the date of the event to enter any applicable coverage changes. Otherwise you must wait until the next Annual Enrollment to make coverage changes, which take effect the next January 1, or until you experience another qualifying life event or special enrollment event.

Retroactive changes to benefits and deductions may be necessary in a few situations, such as late entry of benefit change or missed payroll cutoff, therefore any missed benefit deductions from the benefit effective date will be caught up on future payrolls.

### WHEN COVERAGE BEGINS

Once you have properly completed enrollment, coverage will begin on the first day of the month following 30 days from your date of hire or change in benefit eligible status date if you enroll within this 31-day period. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

The effective date of coverage is the date of the qualifying life event provided you complete the qualifying life event within 31 days of your event. For example, coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change.

### REHIRED EMPLOYEES

If you are an eligible employee rehired within 30 days of your termination date, your benefit elections in effect on the date of your termination are automatically reinstated back to the benefit end date. If you are an eligible employee rehired more than 30 days after your termination date, but within 13 weeks of your termination date, your benefit elections are effective on the first day

of the month following your date of rehire and you must enroll within 31 calendar days of your rehire date. If you are an eligible employee with a rehire date greater than 13 weeks following your termination date, your effective date will be the same as a new employee and you must enroll within 31 calendar days of your rehire date. If you are an eligible employee rehired after the annual enrollment for the next calendar year, you must enroll or re-enroll to have coverage in the next calendar year.

## ANNUAL ENROLLMENT

During Annual Enrollment, held each fall, you can make changes to your benefit elections. The changes take effect the next January 1. If you have not enrolled in the Plan, you can do so during the annual enrollment period. Elections made during annual enrollment remain in effect throughout the calendar year, unless you experience a qualifying life event or special enrollment event (see Qualifying Life Event and Special Enrollment for more information). In general, your elections remain in effect for future years unless you make a change or you are notified by the Company of coverage changes.

## QUALIFYING LIFE EVENT

There may be times that you experience an event in your life that would allow you to make mid-year changes to your benefit elections. The change you make in your elections must be consistent with your qualifying life event. For example, if you adopt a child, you can add your child as a covered dependent; however, you cannot drop your spouse/domestic partner from coverage under the Plan under the adoption event. Note that some qualifying life events are not applicable to particular benefits. When you make a change, or request a change, you must follow applicable Internal Revenue Service rules on what changes are allowed.

| Life Event | Medical, Dental and/or Vision Plans | Spending Accounts | Supplemental LTD | Life Insurance | Other Voluntary Benefits |
|---|---|---|---|---|---|
| **Birth/Adoption** *Having a baby or finalizing an adoption with the court* | Enroll/Change tier | Enroll/Change election | Enroll – No waive | Enroll/Change tier – No waive | Enroll/Change tier |
| **Acquired Guardianship** | Change tier – No Waive | Enroll/Change election | Enroll – No waive | Enroll/Change Tier – No waive | Change tier – No waive |
| **Death of Dependent/Child** | Enroll/Change tier | Decrease only/No waive | Enroll – No waive | Enroll/Change tier | Change Tier – No waive |
| **Death of Spouse/Domestic Partner** | Enroll/Change tier | Enroll/Change election | Enroll/Change tier | Enroll/Change tier | Enroll/Change Tier – No waive |
| **Divorce/Legal Separation** | Enroll/Change Tier – No waive | Enroll/Change election | Enroll/Change tier | Enroll/Change tier | Enroll/Change Tier – No waive |
| **Marriage** | Enroll/Change tier | Enroll/Change election | Enroll/Change tier | Enroll/Change tier | Enroll/Change tier |
| **Gain of Dependent/Child Eligibility** *Your child becomes newly eligible for benefits through another employer or state* | Change tier – No waive | Change election | -- | Enroll/Change tier | Change tier – No waive |

| | | | | | |
|---|---|---|---|---|---|
| **Loss of Dependent/Child Eligibility** *Your child involuntarily loses other benefits coverage through another employer or state* | Change tier – No waive | Change election | -- | Enroll/Change tier | Change Tier – No waive |
| **Gain of Spouse Benefits/Eligibility** *Your spouse becomes newly eligible for benefits through another employer or state* | Enroll/Change tier | Enroll/Change election | Enroll/Change tier | Enroll/Change tier | Enroll/Change tier |
| **Loss of Spouse Benefits/Eligibility** *Your spouse involuntarily loses other benefits coverage through another employer or state* | Enroll/Change tier | Enroll/Change election | Enroll/Change tier | Enroll/Change tier | Enroll/Change tier |
| **Start of Domestic Partnership** | Enroll/Change tier | Enroll/Change election | Enroll/Change tier | Enroll/Change tier | Enroll/Change tier |
| **End of Domestic Partnership** | Enroll/Change Tier – No waive | Enroll/Change election | Enroll/Change tier | Enroll/Change tier | Enroll/Change tier – No waive |
| **Other Life Events** *(Turning 26, loss or gain of state coverage, etc.)* | **Call the Human Resources Centre (HRC) at 1-888-927-7700** | | | | |

**Do not wait to initiate your life event**

You may be required to provide documentation for your life event. It is important to note that you do not need to submit the documentation at the time you initiate the life event. Since you only have 31 calendar days (includes the event date) to change, add or cancel coverage, it is recommended that you initiate the life event immediately in the My Benefits & Retirement enrollment site. You may contact the Human Resources Centre at 1-888-927-7700 for assistance in making a qualifying life event change.

The effective date of coverage is the date of the qualifying life event, except in the case where you become a newly benefit eligible employee for coverage under the Employee Benefit Program of Bank of Montreal/Harris. The effective date for an employee newly eligible for benefits is the 1st of the month following 30 days from the date your increase in standard hours to over 20 hours/week occurred ("newly benefit eligible date"). You must make your benefit elections within 31 calendar days from your newly benefit eligible date.

## HOW TO CHANGE, ADD OR CANCEL COVERAGE

If you experience a qualified life event during the year, you have 31 calendar days from the date of the event to change, add or cancel coverage. Here's how:

1. Go to **Workday**, click on the **My Benefits & Retirement** application
2. Depending on where you are connecting to Workday from, click on **Employees in Canada an US (on BMO Network)** or **Employees in Canada and US (off BMO Network)**

3. Click on the **Log your Life event** tile
4. Choose the Life Event that corresponds to your event, enter the date your life event occurred and **follow the rest of the prompts** to make your election changes
5. After you make the benefit election changes, **verify your benefits summary** to make sure everything is correct and the changes are reflected as you intended. **Keep a copy for your records.**

If you miss the deadline, your next opportunity to enroll, change or cancel coverage is during annual enrollment, unless another qualifying life event occurs that would allow a change. You may file an appeal to request a change, but your right to add or drop coverage is not guaranteed.

**SPECIAL ENROLLMENT**

Under the Health Insurance Portability and Accountability Act (HIPAA), there are special enrollment rules that let you enroll or add your eligible dependents as long as you enroll within 31 days from the date of one of these events:

- If you become married, even though you may have waived coverage initially, you and your spouse/domestic partner and any newly acquired dependents may take advantage of special enrollment.
- If you choose employee only coverage or are not enrolled and you subsequently acquire a new dependent (whether through birth, placement for adoption or adoption), you may elect special enrollment for your spouse and child, or for the child only, and for yourself (if not previously enrolled). For the birth, adoption or placement for adoption of a new dependent you must apply for coverage within 90 calendar days of that birth, adoption or placement for adoption.
- If you opt out of coverage under the Plan because you are covered under another employer's group health plan and you lose coverage under that plan for a reason other than failing to pay premiums or misrepresentation (for example, a qualifying life event), you may elect special enrollment for you and any eligible dependents that were covered under the prior Plan. You are not required to take COBRA continuation under another plan to elect special enrollment under this Plan.
- If you opt out of coverage under the Plan (or you opt not to enroll your dependents) because COBRA continuation is in effect on your eligibility date, you (or your dependents) must exhaust the COBRA continuation period before you can elect special enrollment under the Plan. This means you (or your dependents) must continue COBRA coverage for the entire COBRA period in order to have a special enrollment right under the Plan. Failure to pay a COBRA premium or voluntary termination of coverage does not result in the exhaustion of COBRA.

- If you opt out of coverage under the Plan because you are covered in the individual market, including coverage purchased through a Marketplace health plan and you lose coverage under that plan (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentations of a material fact), you may elect special enrollment for you and any eligible dependents that were covered under the Marketplace plan.

Neither you nor an eligible dependent is required to elect COBRA continuation under another employer's plan or a Marketplace plan to become eligible for special enrollment. However, once you or your dependent elects COBRA continuation, if you also opted out of coverage under this Plan, you and/or your dependents must complete the entire COBRA continuation period before you can enroll in this Plan under the special enrollment provisions.

Special enrollment is also allowed if your other group health plan ends or the employer sponsoring the other group health plan stops making employer contributions. However, you must give notice and actually enroll in the Plan within 31 calendar days of either event. If you fail to do so, you must wait until the next annual enrollment for the Plan, unless you have a subsequent qualifying life event or special enrollment event and give notice within 31 calendar days of the subsequent change.

Changes are effective on the date of the qualifying life event.

## CHILDREN HEALTH INSURANCE PROGRAM AND MEDICAID

You have 60 days to enroll for coverage if:

- you or your dependent's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) ends as a result of loss of eligibility (not available if the loss of coverage is due to non-payment); or

- you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

## FAMILY AND MEDICAL LEAVE OF ABSENCE

You may be able to continue Plan coverage for up to 12 weeks during a leave of absence if that leave qualifies under the Family and Medical Leave Act of 1993 (FMLA) and you are eligible under the terms of FMLA.

To continue your coverage, you must continue paying your premiums while on FMLA leave. If your FMLA leave is paid, your premium contributions are deducted from your pay as usual and your benefits coverage will continue without interruption during your leave. If any portion of your leave is unpaid, your benefits coverage will continue and you will still owe premiums during the unpaid leave. Any missed deductions for your benefits will accumulate in arrears. When you return from leave, your regular deductions will resume and any accumulated arrears will be collected at

a rate of one additional deduction per pay until your arrears balance is zero. For longer periods of unpaid leave, you will be contacted to make payment arrangements for your unpaid premiums.

If, during your FMLA leave, you give notice that you are terminating employment, your coverage ends on the last day of the month in which your employment ends. If you do not return to work on your expected return date and do not notify the Company of your intent either to terminate or extend your leave, your coverage ends on the last day of the month in which your employment ends. Also, you cannot change your Plan coverage tier (e.g., Employee Only) while on FMLA leave, except at annual enrollment or if you have a qualifying life event or special enrollment event. For more information about FMLA leave, access the HR Intranet, Operating Procedures, Leaves of Absence – Family Medical can be found under *About Managing Life's Transitions*.

**MATERNITY AND PARENTAL LEAVE**

If you are on maternity or parental leave your Plan coverage will continue during both the paid and unpaid portion of your leave.

- Your benefits coverage will continue during the first 12 weeks of paid maternity/parental leave. Premiums will continue to be deducted from your pay.
- If you choose to take unpaid maternity/parental leave, your benefits coverage will continue and you will owe premiums. Your premiums will accumulate in arrears. When you return from leave, your regular deductions will resume and any arrears will be collected at a rate of one additional deduction per pay until your balance is zero.

**MILITARY LEAVE OF ABSENCE**

If you are on military leave, you can elect to continue Plan coverage for yourself and enrolled dependents for up to 24 months during your absence or, if earlier, until the day after the date you are required to apply for or return to active employment with the Company under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). During the first 30 days of coverage, your contributions are the same as for active employees and you will be required to pay the active premiums.

Whether or not you decide to continue coverage during military leave, that coverage will be reinstated when you return to employment under USERRA. Your reinstatement will be without any waiting period.

**IF YOU TAKE A LEAVE OF ABSENCE**

You can continue your medical coverage while you are on an approved leave of absence. If you are on a paid leave, your premium is deducted from your pay as usual. If any portion of your leave is unpaid, your benefits coverage will continue and you will still owe premiums during the unpaid leave. Any missed deductions for your benefits will accumulate in arrears. When you return from leave, your regular deductions will resume and any accumulated arrears will be collected at a rate of one additional deduction per pay until your arrears balance is zero. For longer periods of unpaid leave, you will be contacted to make payment arrangements for your unpaid premiums. Your

contribution amount is the same as when you were actively working and is subject to change each January 1.

## IF YOU BECOME DISABLED

Your medical, coverage, if applicable, may continue during your disability leave. Premium payments are deducted from any Short-Term Disability payments you may be receiving. If you are on Long Term Disability, you will be required to send in payment on an after-tax basis to continue your coverage. Please refer to the Disability SPD for detailed information regarding your benefits during your disability.

## RETROACTIVE CANCELLATION OF COVERAGE

The Plan expects that you will provide complete and accurate information. If you or your dependents commit fraud against the Plan or make a misrepresentation, the Plan may take appropriate actions in response to such fraud or misrepresentation. The actions can include a loss of particular benefits or loss of all eligibility for the Plan.

## ELIGIBILITY CLAIMS AND APPEALS

There are two types of claims under this benefit program: eligibility claims and benefit claims. The claims and appeals process differ depending on which type of claim is involved (and, as described below, there is a different process for eligibility claims involving dependent verification). Benefit claims and appeals are handled by a Claim Administrator as described under "How to File a Claim and Appeals Procedures". This section details the process and timing around filing an eligibility claim or appeal.

An eligibility appeal is a claim to participate in a plan option or to change an election to participate during the year. It may be a claim to start, add or stop participation in the Plan -- that is, it could be a claim related to enrollment in a plan or eligibility for coverage in a plan -- or a claim relating to the premium you are being charged for coverage under this benefit program. For instance, you may feel an error was made during annual enrollment that resulted in your being assigned incorrect coverage. In these situations, you should contact the Human Resources Centre (HRC) at 1-888-927-7700 to discuss your concerns.

As described below, the claim process differs depending on whether the claim involves cancellation of coverage or denial of enrollment due to failure to provide dependent verification or not.

### PROCEDURE FOR FILING AN ELIGIBILITY CLAIM INVOLVING DEPENDENT VERIFICATION

If your dependent was not enrolled in the Plan or your dependent's coverage under the Plan was terminated due to your failure to provide any requested dependent verification information or documentation (e.g., failure to provide a marriage certificate for a spouse or failure to provide a birth certificate or proof of adoption for a child), you may file a claim with the Dependent Verification Services team. In order for a communication from you to constitute a valid claim, it must be in writing on a Dependent Verification Claim Initiation Form, include your name and employee ID, and be delivered, along with any supporting comments, documents, records, and other information to:

Dependent Verification Center – Claims and Appeals
P.O. Box 1434
Lincolnshire, IL 60069-1434

Your claim must be received by Claims and Appeals Management within 60 days from the later of the coverage termination date or eligibility enrollment date.

The Dependent Verification Services - Claims and Appeals Management team will respond to your claim in writing within 30 days of the date the claim is received. If Claims and Appeals Management needs additional information in order to determine whether to grant your claim, they will notify you of the additional information needed. If you do not provide that information within 30 days, your claim will be considered invalid.

Please note that submitting an appeal does not guarantee that your dependent(s) will be reinstated on your coverage. As part of the appeal process, you will need to demonstrate that there was an extenuating circumstance that prevented you from being able to complete the verification process within the required timeframe or that an error occurred.

**PROCEDURE FOR FILING AN ELIGIBILITY CLAIM NOT INVOLVING DEPENDENT VERIFICATION**

If your claim does not involve dependent verification and the HRC does not resolve the issue to your satisfaction, you may file a claim. In order for a communication from you to constitute a valid claim, it must be in writing, include your name and employee ID, and be delivered, along with any supporting comments, documents, records, and other information to:

BMO Financial Corp.
DEPT 14613
P.O. Box 64050
The Woodlands, TX 77387-4050
Fax: 1-866-894-6684

The eligibility administrator will review the appeal and the determination to your claim will be provided to you in writing within 30 days of the date the claim is received. If the eligibility administrator needs additional information in order to determine whether to grant your claim, you will be notified of the additional information needed. If you do not provide the requested information within 30 days, your claim will be considered invalid. If after review the request is approved, you must pay any premium, or will be refunded premiums, retroactive to the date of the event and consistent with the eligibility claim.

**APPEAL OF A DENIED ELIGIBILITY CLAIM**

If your eligibility claim is denied, you or your authorized representative may appeal that decision by submitting an appeal request in writing within 60 days of receiving the eligibility claim denial. In order for a communication from you to constitute a valid appeal, it must be in writing, include your name and employee ID, and be delivered, along with any supporting comments, documents, records or other information that you have not previously provided to:

BMO Financial Corp.
Benefits Administration Committee
C/O Appeals
395 N. Executive Drive
Brookfield, WI 53005

For a second level appeal you must be able to prove that your claim falls outside the usual plan rules. In connection with your request for appeal, you may review pertinent plan documents and submit issues and comments in writing. You may also submit additional information about your

claim to the Committee to consider upon reviewing your appeal. Upon request, you will be provided with copies of all documents and information relevant to your claim free of charge.

The Benefit Administration Committee will respond to your appeal in writing of its final decision regarding your claim for benefits under the plan within 60 days (or, 120 days if an extension is required) of the date the claim is received. If the Benefits Administration Committee needs additional information in order to determine whether to grant your claim, they will notify you. If you do not provide the requested information within 30 days, your appeal will be considered invalid. If after review, the Benefits Administration Committee approves the request, you must pay any premiums, or will be refunded premiums, retroactive to the date of the event and be consistent with the eligibility claim.

**LIMITATION OF ACTION**

You cannot bring any legal action against BMO Financial Corp., the Benefits Administration Committee (or any other Claim Administrator), or the Plan, unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against BMO Financial Corp., the Benefits Administration Committee (or any other Claim Administrator), or the Plan, you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against BMO Financial Corp., the Benefits Administration Committee (or any other Claim Administrator), or the Plan.

**MANDATORY VENUE**

Any lawsuit to challenge a final claim determination or to address any other dispute arising out of or relating to the Plan must be brought in federal court in Cook County, Illinois. The federal courts governing Cook County, Illinois, along with the United States Supreme Court, have exclusive jurisdiction over all disputes arising out of or in any way relating to this Plan.

**PLAN COST**

The Company pays a significant portion of the cost for coverage under the Medical Plan. The amount of your premiums depends on which coverage level option you choose (based on which eligible dependents you enroll in your coverage). These premiums are subject to change each year.

**TAX-SAVING ADVANTAGE**

You pay your portion of the cost of coverage with pretax dollars deducted from the first two paychecks of each month. If there is a third pay period in the month, deductions will not be taken (exceptions may apply in certain circumstances such as missed deductions). “Pretax” means that your premium is taken from your paycheck before Social Security, federal and most state taxes are deducted, thereby lowering your taxable income. This in turn lowers the actual cost you pay for coverage and the amount you pay in taxes.

If you enroll a tax dependent domestic partner, the additional premium is equal to that for a spouse. However, if you enroll a non-tax dependent partner, you pay the premium on an after-tax basis and it creates imputed income. For more information, see Domestic Partner Eligibility Requirements, including the Two Options for Domestic Partner Status chart. Your domestic partner's children qualify for coverage only if they are your tax dependents, so children of a domestic partner are subject to the same pretax rates as biological or adopted children.

## TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Health Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Health Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

## IF YOU DIE WHILE EMPLOYED

Survivors of deceased employees may have access to enroll in the Retiree Medical program or apply for continuation coverage under COBRA. Retiree Medical Program access and Company contribution would be based on the retiree group the employee was part of at the time of their death.

If the employee did not meet the requirements for medical coverage under the Retiree Medical Program, surviving dependents may continue medical coverage by applying for continuation coverage under COBRA. COBRA participation is limited to a period of 36 months and is administered by PayFlex Systems USA, Inc. During the 36-month period, covered dependents will pay the active medical employee premiums (and the difference between the full COBRA premium and the active premium will be subsidized by BMO). In a separate mailing, from PayFlex, you will receive information regarding COBRA including monthly premiums and enrollment forms.
If the employee met the requirements for medical coverage under the Retiree Medical Program at the time of their death and both the employee and the survivors were enrolled in the medical plan

immediately before the employee's death; surviving dependents have the option to enroll in the Retiree Medical program or apply for continuation coverage under COBRA. COBRA participation is limited to a period of 36 months and is administered by PayFlex Systems USA, Inc. During the 36-month period, covered dependents will pay the active medical employee premiums (and the difference between the full COBRA premium and the active premium will be subsidized by BMO). In a separate mailing, from PayFlex, you will receive information regarding COBRA including monthly premiums and enrollment forms. **It is important to know that if you choose to enroll in subsidized COBRA coverage for medical instead of Retiree Medical coverage, your rights to enroll in Retiree Medical coverage in the future are forfeited.**

If the survivors cancel coverage at any time, they will no longer be eligible to participate in the Retiree Medical Program and permanently forfeit rights to enroll in this Plan in the future.

## CONTINUTING COVERAGE THROUGH COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliations Act of 1985 (COBRA), as defined in the definitions section. Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. See the section of this benefit booklet entitled "CONTINUATION COVERAGE RIGHTS UNDER COBRA."

## UTILIZATION MANAGEMENT AND REVIEW

The Claim Administrator has established the Utilization Management and Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on the Claim Administrator's Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity review. If requested, services normally subject to a Post-Service Medical Necessity review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Please refer to the definition of Medically Necessary under the *Definitions* section of this booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

The Utilization Management and Review Program requires a review of Inpatient Hospital Covered Services **before** maximum benefits for such services are available:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services
- Certain Outpatient Procedures

For In-Network benefits your Participating Provider is required to obtain Prior Authorization. There is no penalty to you for failure to notify the Claim Administrator.

For Non-Network Benefits you must obtain Prior Authorization from the Claims Administrator as soon as is reasonably possible. If you fail to obtain Prior Authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

### PRIOR AUTHORIZATION

Prior Authorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Service designated by the Claim Administrator in order to be eligible for maximum benefits.

For Inpatient Hospital facility services, your Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Claim Administrator's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about Prior Authorization for services outside of the Claim Administrator's service area, see the section of this benefit booklet entitled "THE BLUECARD PROGRAM."

Failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator, as described in this section, may result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles, and out-of-

pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator. We encourage you to call ahead. The pre-notification toll-free telephone number is on your Identification Card.

Please read the provisions below very carefully. The provisions of this section do not apply to the treatment of Mental Illness and Substance Use Disorder Treatment. The provisions for the treatment of Mental Illness and Substance Use Disorder Treatment are specified in the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet.

**PREADMISSION REVIEW**

- **Inpatient Hospital Preadmission Review**

  **Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.**

  Whenever a non-emergency or non-maternity Inpatient Hospital admission is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

  **Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.**

  In the event of an emergency admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Pregnancy/Maternity Admission Review**

  **Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan.**

  In the event of a maternity admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

- **Skilled Nursing Facility Preadmission Review**

  **Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.**

  Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Coordinated Home Care Program Preadmission Review**

  **Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.**

  Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Private Duty Nursing Service Review**

  **Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.**

  Whenever Private Duty Nursing Service is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

## OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW

Outpatient Service Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan.

Whenever the following Outpatient procedure(s)/services(s), received from a Participating Provider, are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Coordinated Home Care Program services
- Home hemodialysis
- Home Hospice
- Home Infusion Therapy

- All home health services
- Outpatient Infusion Drugs
- Private Duty Nursing
- Transplant evaluations

**Cardiac (Heart related):**

- Lipid Apheresis

**Ears, Nose and Throat (ENT):**

- Bone Conduction Hearing Aids
- Cochlear Implant
- Nasal and Sinus Surgery

**Gastroenterology (Stomach):**

- Gastric Electrical Stimulation (GES)

**Neurological:**

- Deep Brain Stimulation
- Sacral Nerve Neuromodulation/Stimulation
- Vagus Nerve Stimulation (VNS)

**Orthopedic (Musculoskeletal):**

- Artificial Intervertebral Disc
- Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions
- Femoroacetabular impingement (FAI) Syndrome
- Lumbar Spinal Fusion
- Meniscal Allografts and other Meniscal Implants
- Orthopedic Applications of Stem-Cell Therapy

**Pain Management:**

- Occipital Nerve Stimulation
- Surgical Deactivation of Headache Trigger Sites
- Percutaneous and Implanted Nerve Stimulation and Neuromodulation
- Spinal Cord Stimulation

**Surgical Procedures:**

- Orthognathic Surgery; Face reconstruction
- Mastopexy; Breast lift
- Reduction Mammoplasty; Breast Reduction

**Wound Care:**

- Hyperbaric Oxygen (HBO2) Therapy

**Specialty Pharmacy:**

- Medical Benefit Specialty Drugs (Specialty drugs administered by your Provider)

**Non-Emergency Fixed-Wing Ambulance Transportation:**

- Non-Emergency Fixed-Wing Ambulance Transportation - Please refer to the definition of "Non-Emergency Fixed-Wing Ambulance Transportation" under the DEFINITIONS section of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Whenever the following Outpatient services(s), received by a Non-Participating Provider, are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Dialysis
- Elective Surgery

If an Inpatient Emergency Hospital Admission occurs after an Outpatient service, in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Claim Administrator.

The Claim Administrator will send a letter to you, your Physician and the Hospital or facility with a determination of your Prior Authorization review no later than fifteen (15) calendar days after the Claim Administrator receives the request for Prior Authorization review. However, in some instances depending on the timing of the request for review, these letters will not be received prior to your scheduled date of service or procedure.

For specific details about the Prior Authorization requirements for any of the above referenced Outpatient services, please call the customer service toll-free telephone number on the back of your Identification Card. The Claim Administrator reserves the right to no longer require Prior Authorization during your benefit period for any or all of the listed services. Updates to the list of services requiring Prior Authorization may be confirmed by calling the customer service number.

## RECOMMENDED CLINICAL REVIEW

Some services that do not require Prior Authorization may be subject to review for evidence of medical necessity for coverage determinations that may occur prior to services rendered, during the course of care or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations where you have to pay for a non-approved service. The Claim Administrator will review the request to determine if it meets approved Claim Administrator medical policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbsil.com/find-care/where-you-go-matters/utilization-management.com for the Required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card. You or your Provider may request a Recommended Clinical Review.

**Recommended Clinical Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions under this Plan. Please coordinate with your Provider to submit a written request for a Recommended Clinical Review.**

### General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

   A Recommended Clinical Review is not a guarantee of benefits or payment of benefits by the plan. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the member may have become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from the member's health care Provider or pharmacist. In addition to the written request for Recommended Clinical Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

### Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or Post-Service Claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms member eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

### General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

   A Post-Service Medical Necessity Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate. Post-Service Medical Necessity Review does not guarantee payment of benefits

by the plan, for instance a member may become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

**2. Request for Additional Information**

The Post-Service Medical Necessity Review process may require additional documentation from the member's health care Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

## CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

## LENGTH OF STAY/SERVICE REVIEW

**Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.**

Upon completion of the Inpatient or emergency admission review, the Claim Administrator will send a letter to you, your Physician, Provider of services, Behavioral Health Practitioner and/or the Hospital or facility with a determination on the approved length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to the Plan for continued services. If you, your Provider, or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an Ongoing Course of Treatment, the Plan will make a determination on the request/appeal as soon as possible but no

later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

## MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS—WHAT IS NOT COVERED section in this benefit booklet.

**The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.**

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

**Remember that the Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Plan will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Plan.**

**NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.**

## UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.

2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

## APPEAL PROCEDURE

If you, your Physician, Provider of health services, or Behavioral Health Practitioner disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your Identification Card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician, Provider of health services, or Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Blue Cross and Blue Shield of Illinois
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

## FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Management and Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

For In-Network benefits your Participating Provider is required to obtain Prior Authorization. There is no penalty to you for failure to notify the Claim Administrator.

## MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Management and Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

## CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

The Claim Administrator's Behavioral Health Unit has been established to assist in the administration of Mental Illness and Substance Use Disorder Treatment benefits, including Prior Authorization review, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for your Inpatient Hospital admissions and/or Outpatient services for the treatment of Mental Illness and Substance Use Disorders.

Failure to contact the Behavioral Health Unit or to comply with the determinations of the Behavioral Health Unit may result in a reduction of benefits. The Behavioral Health Unit, as described in this section, may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

Prior Authorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Service designated by the Claim Administrator in order to be eligible for maximum benefits.

For Inpatient Hospital facility services, your Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Claim Administrator's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about Prior Authorization for services outside of the Claim Administrator's service area, see the section of this benefit booklet entitled "THE BLUECARD PROGRAM."

Failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator, as described in this section, may result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles, and out-of-pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator. We encourage you to call ahead. The pre-notification toll-free telephone number is on your Identification Card.

### CONTACTING BEHAVIORAL HEALTH

You, your Physician, Provider of services, or your authorized representative may contact the Claim Administrator for a Prior Authorization or Recommended Clinical Review by calling the toll-free number shown on the back of your Identification Card and follow the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 6:00 PM, on weekends, and on holidays, the same behavioral health line is answered by clinicians available for Inpatient acute reviews only. Requests for residential or Partial Hospitalization are reviewed only during regular business hours.

### PRIOR AUTHORIZATION REVIEW

- **Inpatient Hospital Prior Authorization Review**

  **Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.**

In order to receive maximum benefits under this Health Care Plan, you must obtain Prior Authorization for your non-emergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Behavioral Health Unit. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Residential Treatment Center Prior Authorization Review**

  **Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.**

  Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness or Substance Use Disorder is recommended by your Physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Behavioral Health Unit. This call must be made at least one day prior to scheduling of the admission. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

  **Emergency Mental Illness or Substance Use Disorder Admission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.**

  In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Behavioral Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred.

  If the call is made any later than the specified time period, you may not be eligible for maximum benefits. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section.

- **Partial Hospitalization Treatment Program Review**

  **Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.**

  In order to receive maximum benefits under this Health Care Plan, you must notify the Behavioral Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied, as described in this section. The Behavioral Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Behavioral Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

- **Length of Stay/Service Review**

  **Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.**

  Upon completion of the Prior Authorization or Emergency Mental Illness or Substance Use Disorder Review, the Behavioral Health Unit will send you a letter confirming that you or your representative called the Behavioral Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Behavioral Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Behavioral Health Unit Physician for review.

## MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission, Outpatient service, or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Behavioral Health Unit. If the Behavioral Health Unit concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, benefit for some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determinations, with a follow-up notification letter sent to you, your Behavioral Health Practitioner, and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Behavioral Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, "EXCLUSIONS—WHAT IS NOT COVERED."

**The Behavioral Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Behavioral Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, Outpatient service or other health care service is Medically Necessary under the Health Care Plan.**

In the event that the Behavioral Health Unit determines that all or any portion of an Inpatient Hospital admission, Outpatient service, or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

**Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission, Outpatient service, or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Behavioral Health Unit decides they were not Medically Necessary.**

## BEHAVIORAL HEALTH UNIT PROCEDURE

When you contact the Behavioral Health Unit to obtain Prior Authorization for your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Behavioral Health Unit to obtain Prior Authorization for your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Behavioral Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Prior Authorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

## APPEAL PROCEDURE

### Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Behavioral Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Behavioral Health Unit and requesting an expedited appeal. The Behavioral Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Behavioral Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Behavioral Health Unit Physician, you may request an appeal in writing as outlined below.

### Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Behavioral Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30-day period, you may review any relevant documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review, and you will be notified of this during the first 30-day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

## FAILURE TO OBTAIN PRIOR AUTHORIZATION OR NOTIFY

For In-Network benefits your Participating Provider is required to obtain Prior Authorization.

For Non-Network Benefits you must obtain Prior Authorization from the Claims Administrator as soon as is reasonably possible. If you fail to obtain Prior Authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

The final decision regarding your course of treatment is solely your responsibility and the Behavioral Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Behavioral Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

For Outpatient behavioral health services, there is no penalty to you for failure to notify the Claim Administrator. For Substance Use Disorder Treatment, there is no penalty to you for failure to notify the Claim Administrator for Inpatient Hospital admissions, Residential Treatment Centers and Partial Hospitalization Treatment Programs.

## MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

## CASE MANAGEMENT

You may call the Behavioral Health Unit at the number shown on your Identification Card to access a case manager. They may answer questions about your behavioral condition, help you understand what to expect when you are discharged from a behavioral health facility to your home or to another care facility and help coordinate special care you may need. The behavioral health case management program is designed to help those with mental health and/or substance use concerns manage the unique challenges of those conditions. A case manager may reach out to you via phone or letter to offer case management assistance.

## THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois website at *www.bcbsil.com* for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location, and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

### YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

### YOUR DEDUCTIBLE

If you have Individual Coverage, each benefit period you must satisfy a $1,750 benefit program deductible for Covered Services rendered by Participating Provider(s) and a separate $3,500 deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s) before receiving benefits. After you have Claims for Covered Services in a benefit period which exceed this deductible amount, your benefits will begin. The deductible will be referred to as the program deductible.

### FAMILY DEDUCTIBLE

If you have Family Coverage and your family has satisfied the family deductible amount of $3,500 for Covered Services rendered by Participating Provider(s) and a separate $7,000 family deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s), it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) will be required to meet the benefit program deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family deductible amount has been satisfied.

### BLUE DISTINCTION® AND BLUE DISTINCTION SPECIALTY CARE PROGRAM

Blue Distinction® ("Blue Distinction") is a national designation awarded by Blue Cross and Blue Shield Plans to health care Providers. The Blue Distinction Specialty Care program includes two levels of designation: Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+).

The Blue Distinction Specialty Care program focuses on BDC and BDC+ providers that excel in providing safe, effective treatment for specialty care needs.

**BLUE DISTINCTION CENTERS**

The Blue Distinction designation uses nationally consistent criteria to designate high-performing providers based on objective, evidence-based selection criteria. The Blue Distinction Specialty Care program's purpose is to assist you in finding BDC and BDC+ providers that have met overall quality measures for patient safety and outcomes, fewer medical complications, lower readmission rates, and higher survival rates in the administration of specialty care.

Blue Distinction Centers provide care in the following specialty care areas:

- Cardiac Care
- Cellular Immunotherapy (CAR-T)
- Fertility Care*
- Substance Use Treatment and Recovery
- Gene Therapy
- Spine Surgery
- Bariatric Surgery
- Knee and Hip Replacement Surgery
- Maternity Care
- Transplants

* BDC and BDC+ Fertility Care programs are currently supported by plans with Fertility Care programs at the professional level.

**BDC and BDC+ Benefit Differential**

Your plan offers lower out-of-pocket costs when you receive treatment at a BDC or BDC+ Provider for certain services related to Transplant. You may choose to receive treatment at a non-BDC and/or non-BDC+ provider; however, your out-of-pocket costs will be higher. Please refer to your Benefit Highlights section to review the payment levels for procedures performed at a BDC or a BDC+ designated Provider, and procedures performed at other facilities. Blue Distinction benefit levels apply to Blue Distinction facility benefits only, except for Fertility, which offers Professional Provider services.

For additional information regarding Blue Distinction Centers for specialty care, please contact a customer service representative at the toll-free telephone number shown on your Identification Card or visit the following website: www.bcbcs.com/why-bcbs/blue-distinction.

## HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

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

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

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

### INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

#### Inpatient Covered Services

1. Bed, board, and general nursing care when you are in:
   - a semi-private room
   - a private room
   - an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings, and lab work)

#### Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

#### Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

#### Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

You are entitled to benefits for 120 visits in a Coordinated Home Care Program per benefit period.

## BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

### Participating Provider

When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 80% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

### Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

### Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received from a Non-Participating Provider.

## OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

### Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery. In addition, benefits for Covered Services received for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient, and these services are related to Surgery or Medical Care
7. Urgent Care
8. Emergency Accident Care
9. Emergency Medical Care
10. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis
11. Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

## BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

### Participating Provider

Benefits will be provided at 80% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

### Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge after you have met your program deductible.

### Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.

### Emergency Care

Benefits for Emergency Accident Care will be provided at 80% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Accident Care will be subject to the Participating Provider program deductible.

Benefits for Emergency Medical Care will be provided at 80% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Medical Care will be subject to the Participating Provider program deductible.

Each time you receive Covered Services in an emergency room, you will be responsible for a Copayment of $100. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge whether or not you have met your program deductible. The emergency room Copayment will not apply.

If you disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Accident Care or Emergency Medical Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet for specific information on your right to seek and obtain a full and fair review of your Claim.

## WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

## PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

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

For benefits to be available under this Benefit Section, services must be Medically Necessary, and you must receive such services on or after your Coverage Date.

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

Certain services are covered pursuant to the Claim Administrator's medical policies and clinical procedure and coding policies, which are updated throughout the Calendar Year. The medical policies are guides considered by the Claim Administrator when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the benefit Plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsil.com, or call customer service at the number listed on the back of your Identification Card.

### COVERED SERVICES

#### Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

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

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

For non-accident related dental services, if any of the qualifiers below apply to the patient, anesthesia and facility charges related to the dental services are covered:

- Covered Person under age 6.
- Covered Person with a chronic disability and the following three conditions must be met:
- Attributable to medical or physical impairment.
- Likely to continue indefinitely.
- Results in substantial functional limitation (i.e. self-care, learning, ((no age restriction applies)).
- Covered Person has medical condition which requires hospitalization or general anesthesia for dental care (no age restriction applies).

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Surgical removal of cataracts.
4. Sterilization Procedures (even if they are voluntary).
5. Gender reassignment—benefits for Covered Services for gender reassignment Surgery, including related service and supplies, will be provided the same as any other condition.

**A1C Testing**

This plan provides benefits for A1C testing for prediabetes, type I diabetes, and type II diabetes mellitus.

**Biomarker Testing**

This plan provides benefits for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition.

**Blood Glucose Monitors for Treatment of Diabetes**

This plan provides benefits for Medically Necessary blood glucose monitors (including non-invasive monitors and monitors for the blind), if a Physician has provided a written order.

**Comprehensive Cancer Testing**

This plan provides benefits for Medically Necessary Comprehensive Cancer Testing, including, but not limited to, whole-exome genome testing, whole-genome sequencing, RNA sequencing, tumor mutation burden, and targeted cancer gene panels.

**Pancreatic Cancer Screening**

This plan provides benefits for Medically Necessary pancreatic cancer screenings.

**Vitamin D Testing**

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

**Medical Care**

Benefits are available for Medical Care visits when:

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

**Consultations**

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

**Diabetes Self-Management Training and Education**

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

Benefits are also available for regular foot care examinations by a Physician or Podiatrist for paraplegic covered persons who have a disease that requires them to wear leg braces; covered persons who are taking blood thinners; covered persons with decreased circulation; covered persons with severe cardiac health problems; covered persons at high risk for infections such as diabetes.

**Diagnostic Service**—Benefits will be provided for those services related to covered Surgery or Medical Care.

**Emergency Accident Care**

**Emergency Medical Care**

**Electroconvulsive Therapy**

**Allergy Injections and Allergy Testing**

**Chemotherapy**

**Occupational Therapy**

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be

furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Your benefits for Occupational Therapy, Speech Therapy and Physical Therapy are limited to a combined maximum of 60 visits per benefit period. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Occupational Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

**Physical Therapy**

Benefits will be provided for Physical Therapy when rendered by a licensed professional Physical Therapist; provided, however, when the therapy is beyond the scope of the Physical Therapist's license, the Physical Therapist must be under the supervision of a Physician, and the therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Your benefits for Occupational Therapy, Speech Therapy and Physical Therapy are limited to a combined maximum of 60 visits per benefit period. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Physical Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

**Chiropractic and Osteopathic Manipulation**—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 20 visits per benefit period.

**Naprapathy**—Benefits will be provided for naprapathy when rendered by a Naprapath. Benefits for naprapathy will be limited to a maximum of 20 visits per benefit period.

**Radiation Therapy Treatments**

**Speech Therapy**

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Your benefits for Occupational Therapy, Speech Therapy and Physical Therapy are limited to a combined maximum of 60 visits per benefit period. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Speech Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

**Clinical Breast Examinations**—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

**Diagnostic Colonoscopies**

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

Benefits for diagnostic colonoscopies will be provided at no charge after your program deductible has been met.

**Bone Mass Measurement and Osteoporosis**—Benefit will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

**Experimental/Investigational Treatment**—Benefits will be provided for routine patient care in conjunction with experimental/investigational treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with an Approved Clinical Trial program. You and/or your Physician are encouraged to call customer service at the toll-free number on your Identification Card in advance to obtain information about whether a particular clinical trial is qualified.

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

**Acupuncture**—Benefits will be provided for acupuncture when rendered by a licensed acupuncturist. Benefits for acupuncture will be limited to 20 visits per calendar year.

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

**Orthotic Devices**

Benefits will be provided for a supportive device for the body or a part of the body, head, neck, or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs, or replacement of the device because of a change in your physical condition, as Medically Necessary.

**Outpatient Contraceptive Services**

Benefits will be provided for prescription contraceptive devices, injections, implants, and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures, and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

### Prosthetic Appliances

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

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

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

**Routine Pediatric Hearing Examination**—Benefits will be provided for routine pediatric hearing examinations.

**Pulmonary Rehabilitation Therapy**—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

## BENEFIT PAYMENT FOR PHYSICIAN SERVICES

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

### Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 80% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

### Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at 60% of the Maximum Allowance after you have met your program deductible.

### Emergency Care

Benefits for Emergency Accident Care will be provided at 80% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Medical Care will be provided at 80% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

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

If you disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Accident Care or Emergency Medical Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet for specific information on your right to seek and obtain a full and fair review of your Claim.

**Participating and Non-Participating Professional Providers are:**

- Acupuncturists
- Audiologists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Dentists*
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Naprapaths
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Other Professional Providers
- Physical Therapists
- Physicians
- Podiatrists
- Psychologists
- Prosthetic Providers
- Registered Surgical Assistants
- Registered Dieticians
- Retail Health Clinics
- Speech Therapists

*Dentists are Non-Participating Providers, but they will be treated as such for purposes of benefit payment made under this benefit booklet. They may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

Participating Providers have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the

Maximum Allowance for the particular Covered Service—that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Professional Provider, or the Claim Administrator.

## OTHER COVERED SERVICES

This section of your benefit booklet describes "Other Covered Services" and the benefits that will be provided for them.

- The processing, transporting, storing, handling and administration of blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Your benefits for Private Duty Nursing Service are limited to a maximum of 60 visits per benefit period.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration.
- Medical and surgical dressings, supplies, casts, and splints.
- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia. Benefits for wigs will be limited to a lifetime maximum of $500.

## BENEFIT PAYMENT FOR OTHER COVERED SERVICES

**After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.**

**Benefits for ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility) will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance after you have met your program deductible. For ambulances, if not related to a true emergency, the charges should be paid at 60% of Eligible Charge or 60% of the Maximum Allowances after you have met your program deductible.**

**Notwithstanding anything else described herein, Providers of ambulance services will be paid based on the amount that represents the billed charges from the majority of the ambulance Providers in the Metro area as submitted to the Claim Administrator. Benefits for Ambulance Transportation will be paid at the highest level available under this benefit program. However, you will be responsible for any charges in excess of this amount.**

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

**Participating and Non-Participating Professional Providers are:**

- Acupuncturists
- Audiologists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Dentists*
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Naprapaths
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Other Professional Providers
- Physical Therapists
- Physicians
- Podiatrists
- Psychologists
- Prosthetic Providers
- Registered Surgical Assistants
- Registered Dieticians
- Retail Health Clinics
- Speech Therapists

*Dentists are Non-Participating Providers, but they will be treated as such for purposes of benefit payment made under this benefit booklet. They may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

Participating Providers have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider, or the Claim Administrator.

## SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

### HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

— If both the donor and recipient have coverage each will have their benefits paid by their own program.

— If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation, and delivery of the donor organ.

— the removal of the organ from the donor.

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

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

— **Whenever a heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.**

— If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

— The maximum amount that will be provided for lodging is $50 per person per day with a maximum of $100 per day if more than one person.

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

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
- Meals.

## CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

### Benefit Value Advisor

The Benefit Value Advisor (BVA) program has been established to assist members in maximizing their benefits under this benefit booklet. Benefit Value Advisors are trained customer service representatives who assist members by comparing coast and providing information on Participating Providers for certain types of health care services. A BVA helps member navigate their benefits.

In addition to calling the BVA, you may also have other call requirements. A call to the BVA does not satisfy any other call requirements you may have.

## PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided for in this benefit booklet, (and notwithstanding anything in your benefit booklet to the contrary), the following preventive care services will be considered Covered Services and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum (to be implemented in the quantities and within the time period allowed under applicable law or regulatory guidance) when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service:

1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
3. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents;

4. with respect to women, such additional preventive care, and screenings, not described in item 1. above, as provided for in comprehensive guidelines supported by the HRSA; and
5. drugs (including both prescription and over-the-counter) that fall within a category of the current "A" or "B" recommendations of the United States Preventive Services Task Force and that are listed on the ACA Preventive Services Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the Preventive Services Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.

The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the member.

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

The preventive care services described in items 1. through 5. above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Claim Administrator's website at *www.bcbsil.com* or contact customer service at the toll-free number on your Identification Card.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, the Claim Administrator may use reasonable medical management techniques, including but not limited to, those related to setting and medical appropriateness to determine coverage.

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

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

1. Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked
2. Unhealthy alcohol and drug use screening and counseling
3. Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions
4. Aspirin use for men and women for prevention of cardiovascular disease for certain ages
5. Blood pressure screening
6. Cholesterol screening for adults of certain ages or at higher risk
7. Colorectal cancer screening for adults over age 45
8. Depression screening
9. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease
10. HIV screening for all adults at higher risk

11. HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition including baseline and monitoring services
12. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster (Shingles)
    - Human papillomavirus
    - Influenza (Flu shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
    - COVID-19
13. Obesity screening and counseling
14. Sexually transmitted infections (STI) counseling
15. Tobacco use screening and cessation interventions for tobacco users
16. Syphilis screening for adults at higher risk
17. Exercise interventions to prevent falls in adults age 65 years and older who are at increased risk for falls
18. Hepatitis C virus (HCV) screening of infection in adults aged 19 to 79 years
19. Hepatitis B virus screening for persons at high risk for infection
20. Counseling children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
21. Lung cancer screening in adults 50 and older who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years
22. Screening for high blood pressure in adults age 18 years or older
23. Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese
24. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history of CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking) and (c) a calculated 10-year CVD risk of 10% or greater
25. Tuberculin testing for adults 18 years or older who are at risk of tuberculosis
26. Whole body skin examination for lesions suspicious for skin cancer

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

1. Bacteriuria urinary tract screening or other infection screening for pregnant women
2. Perinatal depression screening and counseling
3. BRCA counseling about genetic testing for women at higher risk
4. Breast cancer chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive lactation support and counseling from trained providers, as well as access to breastfeeding supplies for pregnant and nursing women. Electric breast pumps are limited to one per benefit period.
6. Cervical cancer screening
7. Chlamydia infection screening for younger women and women at higher risk
8. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
9. Domestic and interpersonal violence screening and counseling for all women
10. Daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant
11. Diabetes screening after pregnancy
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. Gonorrhea screening for all women
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. HIV screening and counseling for women
16. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
17. Osteoporosis screening for women over age 65, and younger women with risk factors
18. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened
21. Sexually transmitted infections (STI) counseling
22. Syphilis screening for all pregnant women or other women at increased risk
23. Well-woman visits to obtain recommended preventive services
24. Urinary incontinence screening
25. Breast cancer mammography screenings, including breast tomosynthesis and, if Medically Necessary a screening MRI
26. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal
27. Aspirin use for pregnant women to prevent preeclampsia

28. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
29. Behavioral counseling to promote healthy weight gain during pregnancy
30. Behavioral counseling to maintain weight or limit weight gain to prevent obesity for women who are aged 40 or older

**Preventive Care Services for Children (or others as specified):**

1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Critical congenital heart defect screening for newborns
7. Depression screening for adolescents
8. Development screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children ages 9-11 and 17-21
10. Bilirubin screening in newborns
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns, children, and adolescents
15. Height, weight, and body mass index measurements
16. Hematocrit or hemoglobin screening
17. Hemoglobinopathies or sickle cell screening for all newborns
18. HIV screening for adolescents at higher risk
19. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Human papillomavirus
    - Influenza (Flu shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Varicella
    - Haemophilus influenzae type b

- Rotavirus
- Inactivated Poliovirus
- Diphtheria, tetanus, and acellular pertussis
- COVID-19

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

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

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

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

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

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

## WELLNESS CARE

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

- Routine diagnostic medical procedures;
- Routine laboratory tests;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray;
- Routine Pap smear;
- Routine Prostate Test;
- Routine digital rectal examinations and prostate tests.

### Participating Provider

When you receive Covered Services for wellness care from a Participating Provider, benefits for wellness care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

### Non-Participating Provider

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge or 60% of the Maximum Allowance and will not be subject to the program deductible.

## SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board, and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 80% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 60% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

You are entitled to benefits for 60 days of care in a Skilled Nursing Facility per benefit period.

## AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services rendered by a Non-Administrator Ambulatory Surgical Facility will be provided at 60% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

## AUTISM SPECTRUM DISORDER(S)

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder (a) by a Physician or a Psychologist who has determined that such care is Medically Necessary, or (b) by a certified, registered or licensed health care professional with expertise in treating Autism Spectrum Disorder(s), including but not limited to, a health care professional who is eligible as a Qualified ABA Provider by state regulation and when such care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:

- psychiatric care, including diagnostic services;
- psychological assessments and treatments;
- habilitative or rehabilitative treatments;
- therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

Please review the Occupational Therapy, Physical Therapy and Speech Therapy provisions in this benefit booklet.

Note: Covered benefits for clinically appropriate Autism Spectrum Disorder services and Habilitative services will not be denied solely on the basis of where those services are provided.

## HABILITATIVE SERVICES

Your benefits for Habilitative Services with Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all of the following conditions are met:

- a physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
- treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, or Psychologist upon the referral of a Physician; and
- treatment must be Medically Necessary and therapeutic and not Investigational.

## SUBSTANCE USE DISORDER TREATMENT

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these covered services will also be provided for substance Use Disorder Treatment in a Residential Treatment Center. Substance Use Disorder Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

## DETOXIFICATION

Covered Services received for detoxification are not subject to the Substance Use Disorder Treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this benefit booklet, the same as for any other condition.

## MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Inpatient benefit for these Covered services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness or Substance Use Disorder in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

## MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 90 days of date of the birth. Your Family Coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours). Such an earlier discharge may only be provided if there is coverage and availability of a post-discharge Physician office visit or an in-home visit to verify the condition of the infant in the first 48 hours after discharge.

Your coverage also includes benefits for elective abortions.

## FERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, or to promote fertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

### Special Limitations

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm, or embryos from you will be covered if you choose to use a surrogate.
2. Expenses incurred for cryo-preservation or storage of sperm, eggs, or embryos, except for those procedures which use a cryo-preserved substance. Please note, that benefits may be provided for fertility preservation as set forth in the FERTILITY PRESERVATION SERVICES provision of this benefit booklet.
3. Non-medical costs of an egg or sperm donor.
4. Fertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
5. Fertility treatment rendered to your dependents under age 18.

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

Benefits for treatments that include oocyte retrievals are limited to lifetime maximum of four completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered.

## FERTILITY PRESERVATION SERVICES

Fertility preservation is covered when planned cancer or other medical treatment is likely to produce infertility/sterility (letter of medical necessity will need to be supplied). Coverage is limited to: collection of sperm, cryopreservation of sperm, ooctye cryopreservation, ovarian tissue cryopreservation, embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are the responsibility of the member.

## ROUTINE MAMMOGRAMS

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

— one baseline mammogram

— an annual mammogram

Benefits for routine mammograms will be provided for women who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at the age and intervals considered Medically Necessary by their Physician.

If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening and magnetic resonance imaging (MRI) screening of an entire breast or breasts, when determined to be Medically Necessary by your Physician.

### Participating Providers

Benefits for routine mammograms when received from a Participating Provider will be provided at 100% of the Eligible Charge or Maximum Allowance whether or not you have met your program deductible.

### Non-Participating Providers

Benefits for routine mammograms when received from a Non-Participating Provider will be provided at 60% of the Eligible Charge or Maximum Allowance and your program deductible will not apply.

### Benefit Maximum

Benefits for routine mammograms will not be subject to any benefit period maximum or lifetime maximum.

## TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described under this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

## PORT-WINE STAIN TREATMENT

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

## MASTECTOMY-RELATED SERVICES

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

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

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

## VIRTUAL VISITS

Benefits will be provided for Covered Services described in this benefit booklet for the diagnosis and treatment of non-emergency medical and/or behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit. Benefits for such Covered Services will only be provided if you receive them via consultation with a Virtual Provider who has a specific written agreement with the Claim Administrator to provide Virtual Visits to you at the time services are rendered. For more information about this benefit, you may visit the Claim Administrator's website at *www.bcbsil.com* or call customer service at the number on the back of your Identification Card.

Benefits for Covered Services you receive through a Virtual Visit from a Participating Virtual Provider will be provided at the same general payment level for Participating Providers as described under the BENEFIT PAYMENT FOR PHYSICIAN SERVICES provision in the PHYSICIAN BENEFIT SECTION of this benefit booklet.

Benefits will not be provided for services you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with the Claim Administrator to provide Virtual Visits.

Note: Not all medical or behavioral health conditions can be appropriately treated through Virtual Visits. The Virtual Provider will identify any condition for which treatment by an in-person Provider is necessary.

## PAYMENT PROVISIONS

### Lifetime Maximum

Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited.

## TRAVEL BENEFITS

You will be reimbursed for travel expenses for transportation and lodging that you incur for travel that is necessary to obtain any Covered Service rendered by a Participating Provider if there is no Participating Provider able to perform that service located within 100 miles of your home address (such benefits referred to herein as "Travel Benefits"). Coverage is available for you and up to one companion, or, if the person receiving the Covered Service is under age 18, up to two companions. Reimbursement for lodging is limited to $50 per night for you and an additional $50 per night for

each permitted companion. To obtain reimbursement, you will need to submit a form, which includes receipts and supporting documentation of your expenses. Meals are not reimbursable. Travel Benefits are limited to a cap of $4,000 per occurrence. Reimbursement is subject to the service, travel, and reimbursement being in accordance with all applicable laws or regulations.

## OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

### For Participating Providers

If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $3,425, any additional eligible Claims for Participating Providers (except for those charges specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for Covered Services for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care, and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or Non-Administrator Provider
- Copayments resulting from noncompliance with the provisions of the UTILIZATION MANAGEMENT AND REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $6,850 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

### For Non-Participating Providers

If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $6,850, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the emergency room Copayment
- the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services you may receive from a Participating Provider
- the Coinsurance resulting from Hospital services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility for Covered Services
- Copayments resulting from noncompliance with the provisions of the UTILIZATION MANAGEMENT AND REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $13,700 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

**The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**

## EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program, Residential Treatment Center or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

## HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

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

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

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

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

### Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.

## HEARING CARE PROGRAM

Your coverage includes benefits for hearing care when you receive such care from a Physician, Otologist, Audiologist or Hearing Aid Dealer.

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

For hearing care benefits to be available, such care must be Medically Necessary and you must receive such care on or after your Coverage Date.

In addition to the Definitions of this benefit booklet, the following definitions are applicable to this Benefit Section:

AUDIOLOGIST.....means a duly licensed audiologist.

HEARING AID DEALER.....means a Provider licensed to make and provide hearing aids to you.

OTOLOGIST.....means a duly licensed otologist or otolaryngologist.

### Benefit Period

Your hearing care benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

### Covered Services

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

Audiometric Examination
Hearing Aid Evaluation
Conformity Evaluation
Hearing Aids

Benefits will be limited to one Covered Service(s) of each type listed above per benefit period.

### Special Limitations

Benefits will not be provided for the following:

1. Audiometric examinations by an Audiologist when not ordered by your Physician within 6 months of such examination.
2. Medical or surgical treatment.
3. Drugs or other medications.
4. Replacement for lost or broken hearing aids, except if otherwise eligible under frequency limitations.
5. Hearing aids ordered while covered but delivered more than 60 days after termination.

**Benefit Payment for Hearing Care**

Benefits for hearing care Covered Services will be provided at 100% of the Usual and Customary Fee.

Benefits for hearing aids will be provided up to a lifetime maximum of $5,000.

For purposes of this Benefit Section only, the definition of Usual and Customary Fee shall read as follows:

> USUAL AND CUSTOMARY FEE.....means the fee as reasonably determined by the Claim Administrator, which is based on the fee which the Physician, Otologist, Audiologist or Hearing Aid Dealer who renders the particular service usually charges his patients or customers for the same service and the fee which is within the range of usual fees other Physicians, Otologists, Audiologists or Hearing Aid Dealers of similar training and experience in the same geographic area charge their patients or customers for the same service, under similar or comparable circumstances.

## BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled "Medicare Eligible Covered Persons" in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits ("EOMB") in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

## EXCLUSIONS - WHAT IS NOT COVERED

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

— **Hospitalization, services and supplies which are not Medically Necessary.**
No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

— Services or supplies that are not specifically mentioned in this benefit booklet.

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

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

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

— Services or supplies that were received prior to your Coverage Date or after the date that your coverage was terminated.

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

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

— Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Care Program.

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this benefit booklet.

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

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

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

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

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

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.

— Services or supplies for intersegmental traction; all types of home traction devices and equipment; vertebral axial decompression sessions; surface EMGs; spinal manipulation under anesthesia; muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron; and balance testing through computerized dynamic posturography sensory organization test.

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

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this benefit booklet.

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

— Routine foot care, except for persons diagnosed with diabetes, paraplegic covered persons who have a disease that requires them to wear leg braces; covered persons who are taking blood thinners; covered persons with decreased circulation; covered persons with severe cardiac health problems; covered persons at high risk of neurological or vascular disease arising from diseases such as diabetes.

— Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet rich plasma.

— Treatment of tissue damage or disease in any location with platelet-rich plasma.

— Immunizations, unless otherwise specified in this benefit booklet.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability, or mental disability, except as may be provided under this benefit booklet for Autism Spectrum Disorder(s).

— Habilitative Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

— Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet.

— Hypnotism.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Health Care Plan.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

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

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

— Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

— Testing of blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels; urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover; cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby(premature ruptured membranes); and allergen specific IgG measurement.

— Nutritional items such as infant formulas, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins, and herbal supplements, other than those specifically named in this benefit booklet.

— Reversals of sterilization.

— Orthotics therapy.

— Any related services to a non-covered service. Related services are a) services in preparation for the non-covered service; b) services in connection with providing the non-covered service; c) hospitalization required to perform the non-covered service; or d) services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

— Self-administered drugs dispensed by a Physician.

— Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses, and group homes, except for Covered Services provided by appropriate Providers as defined in this benefit booklet.

Any of the following applied behavior analysis (ABA) related services:

— Services with a primary diagnosis that is not Autism Spectrum Disorder;

— Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of “Qualified ABA Provider” in the DEFINITIONS SECTION of this benefit booklet;

— Activities primarily of an educational nature;

— Shadow or companion services; or

— Any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

## PRESCRIPTION DRUG PROGRAM

When you enroll in the Consumer Choice Plan, you automatically receive prescription drug coverage from Express Scripts, the pharmacy benefits administrator. You will receive your Express Scripts prescription ID card shortly after you enroll. You must present your Express Scripts prescription ID card to a network pharmacy when you purchase prescriptions. This card is separate from the Medical Plan ID card. The cost of your prescription will depend on where you get it filled and if it is a generic, preferred brand name or non-preferred brand name drug. Whether you choose retail or home delivery, Express Scripts offers you convenient, low-cost ways to fill your prescriptions.

Prescription drug benefits are subject to the annual deductible and out-of-pocket maximum. There are also certain categories of prescriptions that are considered preventive and therefore not subject to the deductible and either covered at 100% by the Plan or immediately covered at applicable copayment/coinsurance.

## PRESCRIPTION COVERAGE AT A GLANCE

The coverage availability for prescriptions is subject to the terms of the Plan. For specific medication information call the number on the back of your card or visit www.express-scripts.com and log into your account. If you are not yet a member visit the pre-member site at www.express-scripts.com/bmofinancialgroup. The way you and the Plan share in the cost of your prescription drugs varies based on the drug category, as show below.

| Prescription medication category | Examples of medications in this category | Plan coverage |
|---|---|---|
| Affordable Care Act (ACA) Preventive Drug List | Aspirin products, fluoride products, folic acid products, contraceptive methods, smoking cessation products, most vaccines, bowel preps and primary prevention of breast cancer | You pay $0* |
| Expanded Preventive Drug List | Maintenance medications to treat conditions such as high blood pressure, high cholesterol, diabetes, asthma and more | Deductible does not apply; you pay applicable copay or coinsurance based on the Plan's cost share structure |
| Non-Preventive Prescription Drugs | All other covered prescription Medications | After the deductible; you pay applicable copay or coinsurance based on the Plan's cost share structure |

** Not all prescriptions for the listed medications are covered at 100% and are subject to change. Specific criteria, exclusions, and other rules or limitations may apply to all categories (i.e. quantity limit, age, gender).*

| **Prescription Drug Coverage** | **What you pay** | |
|---|---|---|
| | **Participating Pharmacy** | **Non-Participating Pharmacy** |
| Annual Deductible (Includes Medical and Rx) | Individual coverage: $1,750<br>Family coverage $3,500 | Plan deductible applies |
| Annual Out-of-Pocket Maximum (Includes deductible, copays and coinsurance for Medical and Rx) | Individual coverage: $3,425<br>Family coverage $6,850 | Eligible expenses count toward the respective medical individual/family In-Network Out- of-Pocket Maximum |
| **Retail (up to 30-day supply)** | | |
| Generic | $10 copay | Copays same as in-network, but retail pricing applies |
| Formulary (Preferred Brand) | 25%<br>(min $20, max $50) | |
| Nonformulary (Non-Preferred Brand) | 35%<br>(min $40, max $70) | |
| **Retail (90 days)** | | |
| Generic | $20 copay | Copays same as in-network, but retail pricing applies |
| Formulary (Preferred Brand) | 25%<br>(min $40, max $100) | |
| Nonformulary (Non-Preferred Brand) | 35%<br>(min $80, max $140) | |
| **Home Delivery (up to 90-day supply)** | | |
| Generic | $20 copay | Not covered |
| Formulary (Preferred Brand) | 25%<br>(min $40, max $100) | |
| Nonformulary (Non-Preferred Brand) | 35%<br>(min $80, max $140) | |

- If you, or your doctor, request a brand-name medication when a generic equivalent is available, **you will pay the generic copayment, plus the difference in cost** between the brand and the generic. If you are not able to take a generic equivalent due to medical necessity, your doctor may request a review and provide supporting documentation on why the brand is medically necessary. If approved by Express Scripts, you will pay the brand copayment.
- Manufacturer-funded patient assistance for widely distributed specialty medications will not be considered as true out-of-pocket expenses and may not apply to deductible and out-of-pocket maximums.
- Infertility medications have a pharmacy only lifetime limit of $40,000.
- Smart90 Exclusive requires you to fill maintenance medications at a Smart90 retailer (Walgreens or CVS) or through Express Scripts home delivery. Members can get two retail 30 day grace fills for maintenance medications before you must make the switch

for a 90-day supply at a Smart90 network pharmacy.

## PRESCRIPTION DRUG FORMULARY

The Plan includes a list of preferred drugs (both generic and brand name) that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary. The Plan's Formulary is updated periodically and subject to change, to

get the most up-to-date drug information go online to www.express- scripts.com/bmofinancialgroup or call Express Scripts Member Services at 1 -877-795-2926.

Formularies can help you save money by alerting you to more affordable and clinically effective medications. Drugs chosen for the formulary have gone through an extensive review process, guided by an independent panel of clinical experts that review quality and efficacy (they're known to work well, with minimal side effects), safety and cost-effectiveness. In addition:

- a drug may be moved to a higher or lower cost-sharing Formulary tier;
- additional drugs may be excluded from the Formulary;
- a restriction may be added on coverage for a Formulary-covered drug (e.g. Prior Authorization);
- a Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

Drugs that are excluded from the formulary are not covered under the Plan unless approved in advance through a Formulary exception process managed by Express Scripts on the basis that the drug requested is,

- medically necessary and essential to the Covered Person's health and safety and/or,
- all Formulary drugs comparable to the excluded drug have been tried by the Covered Person.

If approved through that process, the applicable Formulary copayment/coinsurance would apply for the approved drug based on the Plan's cost share structure. Absent such approval, Covered Persons selecting drugs excluded from the Formulary will be required to pay the full cost of the drug without any reimbursement under the Plan. If the Covered Person's Physician believes that an excluded drug meets the requirements described above, the Physician should take the necessary steps to initiate a Formulary exception review.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary. Certain drugs even if covered on the Formulary will require Prior Authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as Step-Therapy. As with all aspects of the Formulary, these requirements may also change from time to time.

## DRUG QUANTITY MANAGEMENT, PRIOR AUTHORIZATION, AND STEP THERAPY PROGRAMS

The Prescription Drug Program utilizes Drug Quantity Management, Prior Authorization and Step Therapy Programs.

- For Drug Quantity Management, certain medications have quantity limits to ensure you get the right amount of the medication.

## Here's how Drug Quantity Management works

The Food and Drug Administration (FDA), medical researchers and medicine manufacturers look at individual medicines to determine a recommended maximum quantity considered safe. Drug quantity management provides the medication you need for your health and the health of your family, while making sure you receive them in the amount – or quantity – considered safe, according to the drug manufacturers, the FDA, and the most up-to-date clinical information.

## Here's how Prior Authorization works

Express Scripts pharmacists regularly review the most current research on newly approved medicines and existing medicines and consult with independent licensed doctors and pharmacists to determine which medicines have been proven to be effective.

The first time you try to fill a prescription that needs Prior Authorization (at a retail pharmacy or the Express Scripts), your pharmacist should explain that more information is needed from your doctor to determine whether the medicine is covered by our plan. The pharmacist should ask your doctor to call the Express Scripts Prior Authorization department to initiate a coverage review.

- For Prior Authorization, certain medications require your doctor to ask for and receive approval before they are approved for coverage.

## Here's how Step Therapy works

A panel of independent licensed physicians, pharmacists and other medical experts work with Express Scripts to recommend medicines for the step therapy program. Together, they review the most current research on thousands of prescription medicines tested and approved by the Food and Drug Administration (FDA). Then they determine the most appropriate medicines to include in the program. Medicines are then grouped in categories, or "steps".

- For Step Therapy, certain medications, typically generic or low-cost brands, are used before other more costly medications are covered.

**First-line medicines –** These are the first step and are typically generic and lower-cost brand- name medicines. They are proven to be safe and effective, as well as affordable. In most cases, they provide the same health benefit as more expensive medicines, but at a lower cost.

**Second-line medicines –** These are the second and third steps and are typically brand-name medicines. They are best suited for the few patients who don't respond to first-line medicines. They're also the most expensive options.

Log in to your account at express-scripts.com or call Express Scripts at the number on your member ID card to find out if step therapy applies to the medicine your doctor prescribed. If it does, you can see a list of first-line alternatives. You can give that list to your doctor to choose the medicine your plan covers that best treats your condition.

The first time you try to fill the prescription, whether it's in person or submitted to the Express Scripts to be delivered, your pharmacist should explain that step therapy requires you to try a first-line medicine before a second-line medicine is covered. Since only your doctor can change your current prescription, either you or your pharmacist need to speak with your doctor to request a first-line medicine that's covered by your plan. If you need your prescription right away, you may ask your pharmacist to fill a small supply until you can consult your doctor. NOTE: You might have to pay full price for this small supply.

For information on Formulary medications, Drug Quantity Management, Prior Authorization or Step Therapy programs contact Express Scripts at 1-877-795-2926. To inquire about specific

medications, search medications directly by logging into your account at www.express-scripts.com, or if you are not yet a member, visit the pre-member site at www.express-scripts.com/bmofinancialgroup.

## RETAIL PHARMACY NETWORK

Express Scripts has a large number of participating retail pharmacies across the country where you can purchase smaller quantities of prescriptions to be used for 30 days or less. For example, if your doctor prescribes short-term antibiotics, or you need to quickly get your initial supply of a maintenance drug, just go to a participating retail network pharmacy and present your Express Scripts prescription ID card and pay the applicable copayment or coinsurance.

For a listing of participating network pharmacies, visit www.express-scripts.com, or call Member Services at 1-877-795-2926. If you use a non-participating pharmacy, you must pay the full cost of the prescription and submit for reimbursement. The reimbursement level will be based upon the cost of the drug if you had used an in-network pharmacy. You will be responsible for the amount above the discounted in-network pharmacy rate plus the required copayment/coinsurance.

## HOME DELIVERY

Home delivery, also referred to as mail order, and is designed for longer-term medication supplies of up to 90 days, such as maintenance drugs for chronic conditions like high blood pressure or diabetes. When you need longer-term prescriptions, using home delivery saves you both time and money. Complete the form in your welcome packet or ask your doctor to fax your prescription to Express Scripts.

You can request this form by visiting www.express-scripts.com. If you are a first-time visitor, take a moment to register. Please remember to have your member ID number and a recent prescription number handy. If you do not have a recent prescription number, you may still register; just remember to add a prescription number later so that you can fully manage your prescription benefit online. Once logged in, on the ***Benefits*** tab, simply click on ***Forms.***

## SPECIALTY DRUG PROGRAM THROUGH ACCREDO

Specialty medications are drugs that are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. For these types of prescriptions, you are required to fill your prescriptions through the Express Scripts dedicated specialty pharmacy, Accredo Health Group, Inc.

You may call Member Services at 1-877-795-2926 for information on how to order your specialty medications or to find out more information about Accredo.

## WHAT'S COVERED UNDER PRESCIRPTION DRUGS

Benefits are provided only if the drugs are prescribed by a physician, deemed medically necessary and considered eligible under the plan. Covered drugs may be subject to Express Scripts' clinical programs, including but not limited to Prior Authorization, step therapy, quantity limits and refill too soon.

Generally, covered drugs include the following:

- affordable care act (ACA) preventive drug list
- androgens and anabolic steroids;
- contraceptive emergency kit;
- emergency allergic kits;
- federal legend drugs (drugs that federal law prohibits dispensing without a prescription)
- glucagon emergency kits;
- growth hormones;
- hemophilia factors;
- impotency treatment drugs;
- insulin;
- infertility medications;
- influenza treatments;
- inhaler assisting devices;
- migraine medication;
- non-insulin syringes with or without needles;
- oral contraceptives;
- over-the-counter diabetic supplies (search specific supplies directly by logging into your account at www.express- scripts.com)
- prescription drugs used to treat chemical abuse;
- prescription and over-the-counter smoking cessation aids for those 18 years and older;
- prescription anti-obesity medications topical vitamin A derivatives;
- standard self-injectable medications on Express Scripts' standard drug list;
- specialty medications on Express Scripts' specialty drug list;
- synagis.

## WHAT'S NOT COVERED UNDER PRESCRIPTION DRUGS

The Prescription Drug Program does not cover:

- acts of war: injury or illness caused or contributed to be international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared;
- allergy serums;
- any charge for the administration of prescription products;
- all illegal medications or supplies, even if prescribed by a duly licensed medical professional;
- any medication, prescription or non-prescription which is taken or administered at the place where it is dispensed;
- any medication which is meant to be taken by or administered in whole or in part while the covered person is treated at a hospital, physician's office or extended care facility, but is instead self-administered or administered elsewhere, unless expressly designated by the pharmacy benefits administrator;
- charges that are in access of the contracted amount;

- claims received later than 12 months from the date of service;
- compound prescriptions unless approved by this plan;
- compounded prescriptions delivered through home delivery, except for specialty prescriptions through a specialty pharmacy;
- cosmetic drugs
- difference in cost between a generic product and brand product when the medical professional has not specified a brand product or has not indicated that the brand product is necessary;
- duplicate services and charges or inappropriate billing;
- glucoWatch products;
- hair growth stimulants and products indicated only for cosmetic use;
- injectable contraceptives;
- nutritional supplements;
- ostomy supplies
- over-the-counter contraceptives;
- over-the-counter products, unless specifically provided under this plan;
- non-specialty implantable medications;
- non-systemic prescription contraceptives (i.e. diaphragme, cervical caps, etc.);
- prescription medications which are administered or dispensed as take home drugs as part of treatment while in the hospital or at a medical facility and that requires a physician's prescription;
- prescription products that are not dispensed by a licensed pharmacist or medical professional;
- prescription products dispensed in a foreign country if you traveled solely for the purpose of reimporting prescription drugs into the United States and/or you used other means to ship or bring prescription products from a foreign country into the United States;
- prescription products that may be received without charge under local, state or federal programs, including worker's compensation;
- prescription products that require Prior Authorization or any other clinical process in which the prescription was denied or was needed and not requested;
- prescriptions and prescription refills which exceed the Plan's quantity limits;
- prescriptions or supplies rendered before coverage begins under this Plan or after coverage ends;
- refilling a prescription in excess of the number specified on the prescription or any refill dispensed after one year from the order of the medical professional;
- replacement prescription products resulting from loss, theft, or damage, except in the case of loss due directly to a natural disaster.

If your requested medication or supply is not covered, in whole or in part, you still have the right to purchase that product, however the entire cost of the product will be your responsibility.

## CLAIMING BENEFITS FOR PRESCRIPTION DRUGS LIMITATION OF ACTION

You cannot bring any legal action against BMO Financial Corp. or the pharmacy benefits administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against BMO Financial Corp. or the pharmacy benefits administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against BMO Financial Corp. or the pharmacy benefits administrator. You cannot bring any legal action against BMO Financial Corp. or the pharmacy benefits administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against BMO Financial Corp. or the pharmacy benefits administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such action against BMO Financial Corp. or the pharmacy benefits administrator.

## MANDATORY VENUE

Any lawsuit to challenge a final claim determination or to address any other dispute arising out of or relating to the Plan must be brought in federal court in Cook County, Illinois. The federal courts governing Cook County, Illinois, along with the United States Supreme Court, have exclusive jurisdiction over all disputes arising out of or in any way relating to this Plan.

If you do not present your prescription drug ID card at the time of your purchase at the retail pharmacy, or if you purchase your prescription from a non-participating pharmacy, you will have to submit the claim yourself to Express Script. You can request this form by visiting www.express- scripts.com. If you are a first-time visitor, take a moment to register. Please remember to have your member ID number and a recent prescription number handy. If you do not have a recent prescription number, you may still register; just remember to add a prescription number later so that you can fully manage your prescription benefit online.

Once logged in, on the ***Benefits*** tab, simply click on ***Forms***, and then click on the link to print the retail prescription drug claim form. You can save time and submit your claim online or request claim forms to be mailed to you.

The amount that you will be reimbursed for using a non-participating pharmacy will be based upon the cost of the drug if you had used a participating network pharmacy. You will be responsible for the amount above the discounted in network pharmacy rate plus the required copayment/coinsurance. The reimbursement claim is generally responded to within 10 business days.

## CLAIM DENIALS AND APPEALS

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claims, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the

corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied the diagnosis code and treatment codes to which

the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second le vel appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal or your adverse benefit determination notice or final adverse benefit determination notice does not contain all of the information required under ERISA, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 24 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations 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. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim will be deemed denied.

You have the right to request an urgent appeal of an adverse benefit determination (including a deemed denial) if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call 1-800-864-1135 or send a written request to:

Attn: Urgent Appeals
Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding. You also have the right to bring a civil action under section 502(a) of Employee Retirement Income Security Act of 1974 (ERISA) if your appeal is denied or your adverse benefit determination notice or final adverse benefit determination notice does not contain all of the information required under ERISA. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function you could have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided you simultaneously file your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

## FOR DIRECT CLAIMS

Your plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your plan benefit. To request reimbursement you will send your claim to:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

If your claim is denied, you will receive a written notice within 30 days of receipt of the claim, as long as all needed information was provided with the claim. You will be notified within this 30 day period if additional information is needed to process the claim and a one-time extension not longer than 15 days may be requested and your claim pended until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, you will be notified of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be deemed denied.

If you are not satisfied with the decision regarding your benefit coverage or your claim is deemed denied, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

## COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
   - — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
   - — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

     Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.
3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person, or other organization.

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the Vision Plan ends, you or your covered dependents may be eligible to temporary continue your coverage at your own expense for a limited period. COBRA continuation coverage is available when a qualifying event occurs that causes you or your eligible dependent to lose coverage under the Plan.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- An Employee.
- An Employee's enrolled Dependent.
- An Employee's former Spouse.

Qualifying events for continuation coverage under COBRA
The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

| ***Who can continue coverage*** | ***In what situations*** | ***For how long*** |
|---|---|---|
| **You, your spouse, your eligible children** | • A reduction in your work hours (scheduled to work less than 20 hours a week)<br>• Your termination of employment (except in cases of gross misconduct) | 18 months* |
| **Your spouse** | • Your death<br>• Divorce or legal separation<br>• Employee's entitlement to Medicare (Part A, B, or both)** | 36 months |
| **Your eligible children** | • Your death<br>• Divorce or legal separation<br>• Employee's entitlement to Medicare (Part A, B, or both)**<br>• Children no longer meet the eligibility rule | 36 months |

**Coverage can continue for an additional 11 months if you or a covered dependent is determined to be disabled by the Social Security Administration within the first 60 days of COBRA coverage.*

***The covered employee's Medicare entitlement is a listed triggering event, but it will not be a qualifying event unless it causes a loss of plan coverage.*

Getting started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage and advise you of the monthly cost. The benefits provided under COBRA are the same as those provided to active employees; however, the Company no longer shares the cost with you. You pay the full health care premium, both employee and employer costs, plus a 2% administrative fee.

Under federal law, you have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. **If this election period is missed, you and your eligible dependent(s) will lose the opportunity to continue coverage under COBRA.**

You must make your first payment for continuation coverage within 45 days after the date of your election, and coverage is retroactive to the date your Plan coverage ended. If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

Notification requirements

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage. If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Plan.
- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60-day period, the affected Qualified Beneficiary **will lose the opportunity to continue coverage under COBRA**. If you are continuing coverage under federal law, you must notify the COBRA Administrator within 60 days of the birth or adoption of a child.

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify PayFlex of a disability or a second qualifying event in order to extend the period of

continuation coverage. Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

**You must send this notice to:**
PayFlex Systems USA, Inc.
BENEFITS BILLING DEPARTMENT
P.O. BOX 953374
ST. LOUIS, MO 63195-3374

Disability
If you or a covered dependent is determined to be disabled by the Social Security Administration (SSA) during the first 60 days of COBRA coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify PayFlex of that fact within 60 days of the later of 1) the SSA's determination of disability (the date of the SSA award letter); 2) the date of your qualifying event; 3) the date of your loss of coverage; or 4) the date you were notified of the requirement (the date of your qualifying event letter). The notification must also be provided before the end of the first 18 months of continuation coverage. Coverage exceeding the first 18-month continuation ends when the individual is no longer Social Security-disabled. **You are required to notify the Plan Administrator of any change in your disabled status.** you must notify PayFlex of that fact within 30 days of SSA's determination at the following address:

PayFlex Systems USA, Inc.
Benefits Billing Department
P.O. Box 953374
St. Louis, MO 63195-3374

Second qualifying event
If more than one qualifying event occurs, a maximum of 36 months of COBRA continuation is available. The second qualifying event must occur during the first 18 months of COBRA. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify PayFlex within 60 days after a second qualifying event occurs. **If you fail to alert the Plan administrator of your qualifying event within this 60-day period, you forfeit the right to continued coverage for yourself and your dependents.**

When COBRA coverage ends
COBRA continuation coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing COBRA, you or your dependent(s) becomes covered under another group health plan.
- The date, after electing COBRA, that you or your covered Dependent first becomes entitled to Medicare (Part A or B).
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date the Social Security Administration determines you are no longer disabled, if you have qualified for the 11-month disability extension.

Additional information about COBRA coverage is available in the COBRA Continuation of Rights, located under Legal Notices at www.bmousbenefits.com.

**Once you cancel your continued coverage, you cannot re-enroll.**

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer), the Health Insurance Marketplace or Medicaid within 30 days after your group health coverage ends because of a qualifying event. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**If you are eligible for the Retiree Medical Program** and you elect COBRA health insurance coverage at the time of your retirement, you will forfeit your right to participate in the Retiree Medical Program.

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

**When does COBRA coverage become effective?**

Once you enroll in COBRA coverage and make your first payment, coverage is effective retroactive to the date your active group health coverage ended.

**When can I enroll?**

You, your covered spouse, and/or your covered dependent(s) (covered qualified beneficiaries), have the right to choose COBRA coverage independently. If you or they decide to enroll, COBRA elections must be made within **60** days of the date that coverage is lost or within **60** days of the statement date on the COBRA Group Health Benefits Right of Continuation Coverage Election Notice you receive, whichever is later. If this election period is missed, you and your eligible dependent(s) will lose the opportunity to continue coverage under COBRA.

**Why is COBRA coverage so expensive?**

The monthly premiums for COBRA can come as a surprise if you're accustomed to your employer paying a portion of the cost of health insurance. When you choose COBRA coverage, you must pay the full monthly premium amount (the total of what you and your employer were paying for your coverage), plus a 2% administration fee, as allowed by law. In addition, your first monthly premium payment (due within 45 days of your COBRA enrollment) is likely to be higher than subsequent payments because it may include more than one month of coverage and is retroactive to the date that you lost your employer provided coverage.

**When can I make changes to or drop my COBRA coverage?**

Generally, you, your covered spouse, and other covered dependents have the same rights and restrictions as other plan participants to change your coverage during the year and at annual enrollment. In addition, you have the freedom to make election decisions independently from one another. Keep in mind that enrollment in a Health Care Flexible Spending Account (HCFSA) is limited to individuals participating in a HCFSA at the time of the qualifying event and continues only until the end of the current plan year.

If you want to make a change to or drop your COBRA coverage outside of the annual enrollment period, you may need to demonstrate proof of a qualified change in status (such as marriage, divorce, or the birth or adoption of a child). Make sure you notify the COBRA Administrator of your change in status within the required time period that is stated in the plan rules.

**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.

## CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

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

### Continuation of Coverage

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of "Domestic Partnership" in the DEFINITIONS SECTION of this benefit booklet. 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
## AND APPEALS PROCEDURES

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your Identification Card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed, and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases, the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. 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:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. 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, the date of service and a description of the service and the Claim Charge.
3. 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 should be filed with the Claim Administrator 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 the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

### INTERNAL CLAIM DETERMINATIONS AND APPEALS PROCESS

### INITIAL CLAIM DETERMINATIONS

When the Claim Administrator receives a properly submitted claim, the Claim Administrator will determine benefits in accordance with the Health Benefit Plan provisions. The Claim Administrator will receive and review claims for benefits and will process claims consistent with administrative practices and procedures established by your Plan. You, your valid assignee, your authorized representative, or Provider will be notified of the Claim Administrator's benefit decision. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

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

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

a. The reasons for determination;

b. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative, medical policy or protocol for the determination;

c. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

e. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review;

f. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

h. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;

i. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;

j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the determination was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

k. In the case of a determination 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.

**If You Need Assistance**

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

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

## 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.

The Claim Administrator 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 an Adverse Benefit Determination (or partial determination), then you have the right to a Claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

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

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

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

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees, or a Provider.

### 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 for benefits for medical care or treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

**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 the Claim Administrator 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 the Claim Administrator may request in connection with services rendered to you.

**Urgent Care Clinical Claims***

| Type of Notice or Extension | Timing |
|---|---|
| If your Claim is incomplete, the Claim Administrator must notify you within: | **24 hours**** |
| If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within: | **48 hours after receiving notice** |
| *The Claim Administrator must notify you of the Claim determination (whether adverse or not):* | |
| if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than: | **48 hours** |
| after receiving the completed Claim (if the initial Claim is incomplete), within: | **48 hours** |

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.

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

**Pre-Service Claims**

| Type of Notice or Extension | Timing |
|---|---|
| If your Claim is filed improperly, the Claim Administrator must notify you within: | **5 days*** |
| If your Claim is incomplete, the Claim Administrator must notify you within: | **15 days** |
| If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within: | **45 days after receiving notice** |

| | |
|---|---|
| *The Claim Administrator must notify you of the Claim determination (whether adverse or not):* | |
| if the initial Claim is complete, within: | **15 days**** |
| after receiving the completed Claim (if the initial Claim is incomplete), within: | **30 days** |
| If you require post-stabilization care after an Emergency within: | **the time appropriate to the circumstance not to exceed one hour after the time of request** |

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

**This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator 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 the Claim Administrator expects to render a decision.

**Post-Service Claims**

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

*This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator 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 the Claim Administrator expects to render a decision.

### Concurrent Care

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

## CLAIM APPEAL PROCEDURES - DEFINITIONS

An **"Adverse Benefit Determination"** means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, in response to a Claim, Pre-Service Claim or Urgent Care Clinical Claim, including any such determination, 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 the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

### Urgent Care/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, the Claim Administrator 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, the Claim Administrator 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. The Claim Administrator will render a decision on the appeal within 24 hours after it receives the requested information, but not more than 72 hours from the appeal request.

### Standard or Non-Urgent Appeals

The Claim Administrator will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

### 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 Prior Authorization, or any other determination made by the Claim Administrator 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 the Claim Administrator at the number on the back of your Identification Card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your Claim reviewed. The Claim Administrator 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 the Claim Administrator to request a Claim review. The Claim Administrator 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 the Claim Administrator. 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.

| **Your Right to Appeal** |
|---|
| You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.<br>Send a written appeal request to:<br>The Claim Administrator<br>Claim Review Section<br>P.O. Box 2401<br>Chicago, Illinois 60690 |
| To file an appeal or if you have questions, please call 800-538-8833 (TTY/TDD:711, send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members (BAM) at *bcbsil.com* |

During the course of your internal appeal(s), the Claim Administrator will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon, or generated by the Claim Administrator in connection with the appealed Claim, as well as any new or additional rationale for a determination at the internal appeals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. The Claim Administrator may extend the time period described in this benefit booklet for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial determination 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 the Claim Administrator.

**Timing of Non-Urgent Appeal Determinations**

Upon receipt of a non-urgent concurrent pre-service or post-service appeal, the Claim Administrator will notify the party filing the appeal within five business days of all the information needed to review the appeal.

The Claim Administrator will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 calendar 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 30 calendar days after receipt of 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 have already received the service.

If the appeal is related to administrative matters or Complaints, the Claim Administrator 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**

The Claim Administrator 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 determination 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 the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final determination on internal and external 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 future notices of Claim determinations and certain other benefit information may be available 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 the Claim Administrator;

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.

If the Claim Administrator's or your Employer'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 determination and issue a final decision. Your external review rights are described in the **STANDARD EXTERNAL REVIEW** section below.

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

**Forum Selection**

In the event of any dispute relating to or arising from this Plan, the jurisdiction and venue for the dispute is the United States District Court for the Northern District of Illinois. If, and only if, the United States District Court for the Northern District of Illinois lacks subject-matter jurisdiction over such dispute, the jurisdiction and venue for the dispute is the Circuit Court of Cook County, Illinois.

## STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO). The external review is at no charge to the member.

An "**Adverse Benefit Determination**" means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting

from the application of any 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 the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator's internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
    a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
    c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and
    d. You or your authorized representative have provided all the information and forms required to process an external review.

    You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the determination of benefits.

   The IRO must provide the following:

   a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

   b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

   c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

   d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

   e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719

of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;

(4) The terms of your Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must 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;

(6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous determination);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of Plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

**EXPEDITED EXTERNAL REVIEW**

1. **Request for expedited external review.** Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

   **a.** An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   **b.** A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must

review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

**EXHAUSTION**

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

## GENERAL PROVISIONS

### 1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS AND OTHER ENTITIES

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

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

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator's separate financial arrangements with Provider's work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

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

The Claim Administrator or its subsidiaries or affiliates may also have ownership interests in or financial arrangements with certain Providers who provide Covered Services to covered persons and/or vendors or other third parties who provide services related to the Policy or provide services to certain Providers.

## 2. INTER-PLAN ARRANGEMENTS

### I. Out-of-Area Services

### Overview

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

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

### Inter-Plan Arrangements Eligibility – Claim Types

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

### A. BlueCard® Program

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

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

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

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

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

a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your Identification Card to the provider to let him or her know that you are covered by the Claim Administrator.

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

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

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

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

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

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

**B. Negotiated (non–BlueCard Program) Arrangements**

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

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

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

**C. Special Cases: Value-Based Programs**

*BlueCard® Program*

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

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

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

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

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

**Negotiated (non-BlueCard Program) National Account Arrangements**

As an alternative to the BlueCard Program, your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

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

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

### a. Member Liability Calculation

(1) In General

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

(2) Exceptions

In some exception cases, the Claim Administrator may, but is not required to, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then the Claim Administrator may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area (and described in Section (a)(1) above); or
2. The following:
    a. For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or
    b. For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

## F. Blue Cross Blue Shield Global Core

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

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator,

working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

If considered True Emergency Medical Care Covered Services will pay 80% after you met the Annual Deductible. Non-Emergency Medical Care Covered Services will pay 60% after you meet the Annual Deductible.

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

**Servicing Plans**

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans ("Servicing Plans") to provide, on the Claim Administrator's behalf, Claim Payments, and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator's behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers ("Servicing Plan Providers") in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan's applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Health Care Plan will be calculated on the basis of the Servicing Plan Provider's Eligible Charge for Covered Services rendered to you or the cost agreed upon between the

Servicing Plan and the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state's statutory method.

**Claim Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers**

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC. Neither the Employer nor you are entitled to receive any portion of such rebates.

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

Note: This applies to drugs that are paid under the medical plan.

## 3. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator 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 Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator 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 Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a covered person. Coverage under this Health Care Plan 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.

**4. YOUR PROVIDER RELATIONSHIPS**

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

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

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

d. Each Provider provides Covered Services only to you and does not interact with or provide any services to your Employer (other than as an individual covered person) or your Employer's ERISA Health Benefit Program.

**5. NOTICES**

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

**6. LIMITATIONS OF ACTIONS**

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

## 7. INFORMATION AND RECORDS

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

## 8. OVERPAYMENT

If your group's benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your group's benefit plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or

b. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to a Contracted Provider; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy, if the future benefit payment owed is to a Contracted Provider; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future payment owed to one or more Contracted Providers.

Further, the Claim Administrator has the right to reduce your benefit plan's or policy's payment to a Contracted Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same Contracted Provider and to remit the recovered amount to the other Blue Cross and Blue Shield's plan or policy.

## 9. VALUE BASED DESIGN PROGRAMS

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

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

**BENEFIT BOOKLET**
**NO SURPRISES ACT AMENDMENT**

**Amendment Effective Date:** This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the benefit booklet to which this Amendment is attached and becomes a part of the benefit booklet. Unless otherwise required by Federal or Illinois law, in the event of a conflict between the terms on this Amendment and the terms of the benefit booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any Member, including Subscriber and Dependents.

The benefit booklet is hereby amended as indicated below:

## I. Continuity of Care

If You are under the care of a Participating Provider as defined in the benefit booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the benefit booklet.

## II. Federal No Surprises Act

### 1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the benefit booklet and this Amendment, those terms will apply only to their use in the benefit booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- Covered Services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of Illinois (BCBSIL) for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

**2. Federal No Surprises Act Surprise Billing Protections**

**a.** The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

**b. Claim Payments**

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

**c. Cost-Sharing**

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your Participating Provider deductible and/or out-of-pocket expense limit, if any.

### 3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

**NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.**

## SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Subrogation and Reimbursement section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which a third party is considered responsible.

***Subrogation – Example***
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

***Reimbursement – Example***
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury or damages, or who is legally responsible for the Illness, Injury or damages.

- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury or damages.

- The Plan Sponsor in a workers; compensation case or other matter alleging liability.

- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility or any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments or other recoveries paid or payable to You or Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any “made-whole doctrine” or “make-whole doctrine,” claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative’s trust account.

- By participating in and accepting benefits from the Plan, You agree that:
  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and;
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys’ fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan’s rights to recovery will not be reduced due to Your own negligence.

- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan’s rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer’s legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgement, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate’s name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations when the date of the claim is denied.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claims, the provisions of this section apply to Your estate, the personal representative of Your estate and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds or any other recovery by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian or other representative of a Dependent Child who incurs an Illness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If a third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by Your or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

# ADMINISTRATIVE INFORMATION

## PLAN IDENTIFICATION

### Plan Name

This Summary Plan Description describes the Medical Plan of the Employee Benefit Program of Bank of Montreal/Harris. The Group Medical Plan of Bank of Montreal/Harris is also called the "Medical Plan", "Health Care Plan" or "Plan" in this Summary Plan Description. The Plan, a group health plan subject to the Health Insurance Portability and Accountability Act (HIPAA), provides medical, prescription drug, mental health and chemical abuse, dental, vision, Spending Account and pre-tax premium benefits.

### Plan Number

507

### Employer Identification Number

51-0275712

### Plan Year

January 1 – December 31

### Plan Sponsor

BMO Financial Corp.
Employee Benefit Program of Bank of Montreal/Harris

### Plan Administrator

Benefits Administration Committee

The plan sponsor and Plan administrator can be contacted at:

BMO Financial Corp.
Benefits Administration Committee
111 West Monroe Street, 7W
Chicago, IL 60603

Human Resources Centre (HRC): 1-888-927-7700

The Plan Administrator has complete discretionary authority to make all determinations under the Plan, including eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Plan. It is the principal duty of the Committee to see that the terms of the Plan are carried out for the exclusive benefit of persons entitled to participate in the Plan. To the extent not delegated to another named fiduciary or to a Claim Administrator, the Committee shall have full discretionary power to administer the Plan in all of its details, subject to applicable

requirements of law. The Committee shall have discretionary and final authority to interpret the terms of the Medical Plan regarding matters for which it is responsible as set forth above and its decisions shall be final and binding on all parties.

The Plan Administrator has delegated to the Claim Administrator the discretionary authority to make decisions regarding the interpretation and application of Plan provisions, to make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Plan and to make claims and final appeals determinations under the Plan. Benefits under the Plan will only be paid if the Plan Administrator or the Claim Administrator, as applicable, determines in its discretion that the claimant is entitled to them.

**Plan Trustee**

The Plan trustee for The Employee Benefit Program of Bank of Montreal/Harris (except for the accident insurance plans and cafeteria plan) is:

BNY Mellon
One Mellon Center, Suite 1315
Pittsburgh, PA 15258-0001

**Agent for Service of Legal Process**

The Plan administrator is the agent for legal process against the plan. Legal process may also be served upon the Plan trustee.

**Type of Funding**

Medical Plan contributions are made by the Company and participating employees. The Medical Plan is self-insured and funded through a trust, with Blue Cross and Blue Shield of Illinois acting as the Claim Administrator. The BMO Financial Group U.S. Retiree Medical Program is funded through participant and employer contributions (Previously contributed to the Employees' Retirement Plan of the Bank of Montreal/Harris under a 401(h) arrangement) which are deposited to the BNY Mellon BMO Retiree Medical Processing Account. If you are a former M&I employee, retiree, long-term disability participant or key retiree* and are eligible for the Plan based upon the legacy M&I Retiree Medical Eligibility provisions, funding is made through participant contributions which are deposited to the M&I Retiree Health Benefits Trust account and employer contributions which were funded into the M&I Retiree Health Benefits Trust at the time of the BMO merger. Benefits for key retirees* are funded through a Rabbi Trust and special key retirees* are funded by employer purchase of insurance or payments from the employer's general assets. BNY Mellon acts as trustee for the BMO Financial Group U.S. Retiree Medical Program for funds deposited into the BNY Mellon Trust. BMO Financial Corp. acts as trustee of the M&I Retiree Health Benefits Trust and the Rabbi Trust. Independent third parties administer claims submitted under the Plan.

* Key retirees are defined as individuals who receive funding based on a specific individual merger related agreement. Special key retirees are defined as individuals who receive funding based on their individual agreement.

## Claim Administrators and Service Providers

The Company has different Claim Administrators for the Medical Plan as shown below:

| Claim Administrator | For | Address for Filing Claims |
|---|---|---|
| Blue Cross and Blue Shield of Illinois<br>300 East Randolph Street<br>Chicago, IL 60601<br><br>www.bcbsil.com<br><br>Member Services: 1-888-979-4516 | Medical benefits and Prior Authorization under the Blue Cross and Blue Shield Consumer Choice Plan | Initial Claim:<br>Blue Cross and Blue Shield<br>P.O. Box 805107<br>Chicago, IL 60680-4112<br><br>Claims Review/Appeals:<br>Claim Review Section<br>Health Care Services Corporation<br>P.O. Box 2401<br>Chicago, IL 60690 |

| Service Provider | For | Address for Filing Claims/Appeals |
|---|---|---|
| Alight Solutions –HR Benefits<br>DEPT 14613<br>P.O. Box 64050<br>The Woodlands, TX 77387-4050<br><br>Member Services:<br>1-888-927-7700 | Processes eligibility and provides customer service to covered individuals | Benefits Administration Committee |
| Dependent Verification Service (DVS) | Submitting initial dependent Verification documents | Dependent Verification Service (DVS) PO Box 1401<br>Lincolnshire, IL 60069-1401 |

| COBRA Administrator | For |
|---|---|
| PayFlex Systems USA, Inc<br>Benefits Billing Department<br>P.O. Box 953374<br>St. Louis, MO 63195-3374<br><br>Member Services: 1-888-678-7835 | COBRA continuation coverage |

## Uncashed Checks

Benefit payment or reimbursement checks under the Plan that relate to benefits that are paid from the bank's or the company's general assets and that remain uncashed after 180 days (or, if later, the expiration date set forth on the reimbursement check) shall be returned to the bank or the company, as applicable. Benefit payment or reimbursement checks under the Plan that relate to benefits that are paid from the trust fund and that remain uncashed after 180 days (or, if later, the expiration date set forth on the reimbursement check) shall be returned to the trust fund. The treatment of uncashed checks relating to benefits under the Plan that are paid by an insurer shall be determined by the insurer.

## Future of the Plan

The Company intends to continue the Plan indefinitely. However, the Company reserves the right to amend, modify, replace or terminate the Plan or part of the Plan at any time for any reason. The Company takes such action through Board of Directors' resolutions or through an administrative committee or other persons authorized by the board of directors. In such case, you would be properly notified of any changes, and all changes would be subject to the Plan's provisions and applicable laws. Keep in mind, health care benefits do not vest like retirement plan benefits. If the Plan is terminated, you will not receive any further benefit under the Plan other than payments of benefits for losses or covered expenses incurred before the Plan was terminated.

## Privacy Information

During the administration of the Plan, certain Company employees and Claim Administrators may come into contact with what is considered "protected health information" under the Health Insurance Portability and Accountability Act (HIPAA).

As part of our compliance efforts, we have previously provided a privacy notice to employees that describe the Plan's use and disclosure of your protected health information, as well as your rights and protections under the HIPAA privacy law. If you would like to receive another copy of the privacy notice, or just need more information, please contact the Privacy Officer, Director of US Benefits, by emailing: BMOHR.USBenefits@bmo.com.

If you are enrolled in the Vision plan, contact the Vision plan to receive another copy of the applicable privacy notice.

## Your Rights Under ERISA

As a participant in the Employee Benefit Program of Bank of Montreal/Harris, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

## Receive Information About Our Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated Summary Plan Descriptions. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

## Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide all of the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims procedure as described in this SPD. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries use the Plan's money, or if

you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

**Assistance With Your Questions**

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration at 1-866-444-3272.

**No Employment Guarantee**

This document does not create a contract of employment between BMO Financial Corp. (the Company) and any employee. Being a participant in the Plan does not grant any current or future employment rights. And, Plan participation is not a condition of employment.

**Medicaid and the Children's Health Insurance Program (CHIP)**

Some states offer premium assistance programs that can help pay for Company-sponsored health care coverage. These states use funds from their Medicaid Program or CHIP when you need assistance in paying health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available. If you are **not** currently enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office, call **1-877-KIDS NOW**, or visit **www.insurekidsnow.gov** to find out how to apply.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, you and your dependents may enroll in the Company Medical Plan – as long as you and your dependents are eligible for the Plan. **You must request coverage within 60 days of being determined eligible for premium assistance.**

## END OF BENEFIT BOOKLET

The information which follows is provided to you by BMO Financial Corp. The Claim Administrator is not responsible for its contents.

### About this Summary

This is the Summary for the BMO Financial Group U.S. Retiree Medical Program ("the Retiree Medical Program" or "the Plan"), a participating plan in the Employee Benefit Program of Bank of Montreal/Harris. The Company reserves the right to discontinue, amend or replace the Plan at its discretion at any time for any reason. If you have further questions about the Retiree Medical Program, please contact the Human Resources Centre at 1-888-927-7700.

### Important Notice

The information in this summary is based on Bank of Montreal/Harris benefit plans in effect as of January 1, 2022. The official plan document contains the full Plan details. If the Summary Plan Description or any oral representation differs from the Plan document, the Plan document prevails.

BMO

# Retiree Medical Program Appendix

**Employee Benefit Program of Bank of Montreal/Harris**

# *Contents*

# *About this Summary*

This is the Summary for the BMO Financial Group U.S. Retiree Medical Program ("the Retiree Medical Program" or "the Plan"), a participating plan in the Employee Benefit Program of Bank of Montreal/Harris. The Company reserves the right to discontinue, amend or replace the Plan at its discretion at any time for any reason. If you have further questions about the Retiree Medical Program, please contact the Human Resources Centre at 1-888-927-7700. The official plan document contains the full Plan details. If the Summary Plan Description or any oral representation differs from the Plan document, the Plan document prevails.

# *Retiree Eligibility*

You and your eligible dependents may be able to participate in the Retiree Medical Program if you meet the criteria to qualify for the program that was in place at the time that you retire(d).

You are not eligible to participate in the Retiree Medical Program if, while an employee, you perform services for the Company under an agreement or arrangement between the Company and a third party; which designates you as an independent contractor or consultant; or which excludes you from Plan participation. You are not eligible for retiree medical coverage if your employment with the Company is terminated due to misconduct, including but not limited to, dishonesty, theft, embezzlement, disclosure of trade secrets, commission of a felony or inappropriate behavior; or if you voluntarily terminate your employment after having committed such acts.

The Retiree Medical Program was redesigned effective January 1, 2008 and employees were classified into eligibility groups to determine what benefits and funding would be offered to you and your dependents during retirement. Your age and years of service, as of December 31, 2007, were used to determine your eligibility group. See How BMO Contributes for more information.

## *Dependents*

At the time of your retirement your eligible dependents can enroll in the retiree medical program, regardless of whether they were enrolled in the active medical plan. However, if they were not on your active medical plan, then they need to have a qualified loss of other group coverage life event in order to enroll. The only exception to this is a birth or adoption, in which case, the new child may be added to coverage within 31 days of the event. Children are allowed to stay on coverage until the end of the month in which they turn age 26, at which time they will be offered COBRA (qualified disabled adult children may be able to stay on after age 26).

The member verification section on the Retiree Medical Program Election/Waiver form must be completed for all eligible dependents regardless if you will be enrolling them in a medical plan at the time of retirement. If you and/or your dependents are waiving retiree coverage, by declaring your eligible dependents you are maintaining their future eligibility to enroll later if they continue to meet eligibility requirements at that time.

Dependents that are not declared on this form at the time of your retirement will not be allowed to participate in the BMO Retiree Medical Program in the future, except for new biological or adopted children.

Your dependents do not need to be enrolled in BMO's medical plan when you retire. The dependent must meet the definition of an eligible dependent at the time of your retirement and at the time you request to enroll them in coverage. You are only able to add the following members to your medical coverage later if they continue to meet the dependent definition, as applicable:

- Your legal spouse or your qualified domestic partner at the time of your retirement date
- Your existing eligible dependent children at the time of your retirement

## *Qualifications for Coverage*

You (and your eligible dependents) qualify for the Retiree Medical Program if:

- you retire at age 55 or older with at least 10 years of service with any BMO entity; and

- you are working as a U.S. employee immediately preceding your retirement; and
- you are enrolled in a Company-sponsored medical plan immediately prior to retirement.

Different eligibility requirements and contribution percentages may apply if you were hired through one of the acquisitions or mergers as stated under Companies Acquired by BMO Financial Group U.S.

**Coverage when you become Medicare eligible (because of age or disability) is not available if you were hired or rehired on or after January 1, 2008, or younger than age 35 as of December 31, 2007**.

## *Special Eligibility Rule for Employees of Divested Companies*

If your employment with the Company ends in connection with a sale or other divestiture that occurs on or after June 1, 2015 and all of the conditions set forth below are met, you will be eligible to participate in the Retiree Medical Program on the date that you would have first become eligible to participate in the Program had your employment with the Company not ended:

- You are employed by the successor company immediately following the sale or other divestiture;
- You would have been eligible to participate in the Retiree Medical Program within two years of the date of the sale or other divestiture had you remained an employee of the Company; and
- The sale agreement or other document authorizing such sale or divestiture provides for special Retiree Medical Program eligibility as described in this section.

## *Companies Acquired by BMO Financial Group U.S.*

You are eligible for retiree medical coverage if you meet the requirements described above. Generally, your eligibility for the Retiree Medical Program starts on the later of the actual (closing) date your company was acquired or the date your company joined the Bank of Montreal/Harris Retirement Plan, whichever is later.

For certain acquisitions (which are asterisked in the chart below) your period of employment going back to your latest hire date with the acquired company may be recognized for purposes of determining eligibility in the Retiree Medical Program.

| Acquired Company | Acquisition Date |
|---|---|
| Argo State Bank* | July 31, 1982 |
| Chemical Bank | January 3, 1984 |
| National Westminster Bank USA | January 18, 1985 |
| Bank of Montreal* | January 1, 1986 |
| Derivative Markets | March 20, 1986 |
| Wilmette | January 1, 1987 |
| Marine Midland National Bank | September 20, 1985 |
| Naperville | January 1, 1988 |
| Barrington* | January 1, 1989 |
| Roselle* | January 1, 1989 |
| Batavia | January 1, 1989 |
| Glencoe-Northbrook | January 1, 1989 |
| Hinsdale | January 1, 1989 |
| St. Charles | January 1, 1989 |
| Winnetka | January 1, 1989 |
| Libertyville* | May 1, 1990 |
| Frankfort | October 1, 1990 |
| Nesbitt Thompson Securities* | April 1, 1992 |

| | |
|---|---|
| Suburban | January 1, 1995 |
| Household | June 29, 1996 |
| Burns Fry* | January 1, 1997 |
| KeyCorp* | January 2, 1997 |
| Burke, Christensen & Lewis (BCL) | January 1, 2000 |
| Village Bank of Naples | July 3, 2000 |
| Freeman Welwood | October 1, 2000 |
| Century Bank | December 15, 2000 |
| First National Bank of Joliet | July 13, 2001 |
| CSFB Direct | February 1, 2002 |
| Northwestern Trust | April 1, 2002 |
| MyCFO | November 1, 2002 |
| Sullivan, Bruyette, Speros and Blayney (SBS) | January 16, 2003 |
| Gerard Klauer Mattison (GKM) | July 3, 2003 |
| Lakeland Community Bank | February 27, 2004 |
| New Lenox State Bank | June 1, 2004 |
| Mercantile National Bank | December 30, 2004 |
| Villa Park Trust and Savings Bank | January 1, 2006 |
| First National Bank & Trust (FNBT) | January 4, 2007 |
| Fidelity Information Services | January 1, 2007 or on employee hire date with Harris N.A., whichever is later |
| Merchants & Manufacturers Bancorporation, Inc. | March 1, 2008 |
| Ozaukee Bank | March 1, 2008 |
| Griffin, Kubik, Stephens & Thompson | July 1, 2008 |
| Pierce, Givens & Associates, LLC | February 13, 2009 |
| Stoker Ostler Wealth Advisors | September 9, 2009 |
| Citicorp Diners Club Inc. | January 1, 2010 |
| Amcore N.A. | April 24, 2010 |
| Marshall & Ilsley Corporation[1] (M&I) | July 6, 2011 |
| CTC Consulting LLC | June 1, 2012 |
| General Electric Transportation Finance | December 1, 2015 *(Service date varies depending on hire date.)* |
| Greene, Holcomb, Fisher, LLC | August 1, 2016 |
| FIS | April 8, 2017 |
| KGS Alpha | September 1, 2018 |
| Clearpool Group Inc. | April 6, 2020 |
| PeopleScout | July 1, 2020 |
| Radical | December 1, 2022 |
| Bank of the West | February 1, 2023 |

## *Special Eligibility Provisions for Marshall & Ilsley Corporation Acquisition*[1]

If you were an employee of M&I refer to Legacy M&I Retiree Medical Eligibility for important details that are available to you and your eligible dependents.

If you were rehired after M&I's acquisition (closing) date with BMO and were not retiree medical eligible when you terminated the first time, see How BMO Contributes for more information.

# *Enrolling & changes*

## *Retirees Under Age 65 and not Medicare Eligible*

When you retire, you will continue in the same medical plan coverage option that you had while you were actively working.

## *Retirees Over Age 65 and/or Medicare Eligible*

Medical coverage for retirees (and their eligible dependents) who are Medicare Eligible because of age or disability are covered under the Medicare Secondary Plan. The Medicare Secondary Plan is a comprehensive plan that coordinates benefits with Medicare and is administered by UMR**.** When you enroll in the Medicare Secondary Plan, **you are required to enroll in Medicare Parts A and B.** The Medicare Secondary Plan is the only option available to retirees and their eligible dependents.

## *Coverage Options*

Retirees are eligible to enroll in the following tiers: Retiree Only or Spouse Only, Retiree + Spouse, Retiree + Child(ren) or Spouse + Child(ren), Child(ren) Only, or Family.

You decide which coverage option best meets your and your family's needs. In cases where both the retiree and their eligible dependents are under age 65 (not Medicare Eligible) all must enroll in the Family coverage level in the same coverage option under the retiree. You are not able to choose a separate coverage option for yourself and each of your eligible family members.

In cases where the retiree or eligible dependent(s) is Medicare Eligible because of age or disability but the other individual(s) is under 65 and not Medicare Eligible, coverage will be split. The individual that is Medicare Eligible will enroll in the Medicare Secondary Plan and the individual not Medicare Eligible will enroll in the Consumer Choice Plan option. Any non-Medicare Eligible children will be covered with the individual who is not Medicare Eligible or enrolled in the Child(ren) Only tier.

In cases where both the retiree and their eligible dependent(s) are Medicare Eligible because of age or disability, coverage will be split. Both individuals will be enrolled in the Medicare Secondary Plan, each with individual coverage. If there are remaining eligible children, the children will be enrolled in the Consumer Choice Plan option, if the child is not also Medicare Eligible.

In cases where the retiree no longer qualifies for coverage, any dependent(s) enrolled in coverage will also be impacted and no longer be eligible for coverage.

**In the event a Retiree actively elects to cancel their retiree medical coverage any dependent(s) enrolled in coverage will also be cancelled and no longer eligible for coverage.**

**Medical Coverage When You and Your Spouse/Domestic Partner Both Work at the Bank**
In situations where you and your spouse/domestic partner are employees of the Company, there may be different alternatives for continuing medical coverage at retirement. Here are some examples of the options that may be available to dual employed couples.

- If both employees retire from the Company and both are eligible for retiree medical coverage (age 55 or older with 10 or more years of benefit service), each may enroll for single retiree medical coverage with premiums based on his or her own years of service. Or, one retiree may choose to enroll as the dependent of the other, provided at least one retiree qualifies for retiree medical.

- If one employee retires while the spouse continues working at the Company, the working spouse may remain in the active plan and enroll the retiree as a dependent. If the working spouse leaves or retires from the Company, they may be enrolled as the dependent of the retiree within 31 days from the last day of work.

## *Becoming Medicare Eligible*

**If you or your dependent(s) become Medicare Eligible as a result of a disability prior to turning age 65, it is your responsibility to inform BMO.**

Retirees and dependents that are considered Medicare Eligible, because of age or disability, are covered under the Medicare Secondary Plan, administered by UMR for medical coverage and Express Scripts for prescription drug coverage. The Medicare Secondary Plan is a comprehensive plan that is designed to coordinate benefits with Medicare and therefore you will need to enroll in Medicare Parts A & B.

Your medical coverage will automatically change to UMR and your premium amount will be automatically updated on the first day of the month in which you turn 65 and qualify for Medicare or the first day of the prior month in cases where the date of birth is on the first of a month. If there are individuals under the age of 65 that were covered on your pre-65 coverage, they will remain covered on their current pre-65 plan until becoming Medicare Eligible or no longer meeting the criteria of an eligible dependent.

If you and/or your dependents choose to waive or cancel your post-65 coverage, please complete and return the Retiree Medical Program Election/Waiver form indicating your election. You are encouraged to return your forms as soon as possible to expedite the set-up of your retiree medical coverage or to update your status if you are waiving post-65 coverage.

## *Eligibility for Medicare Part D (Medicare drug plan)*

You (and your covered dependents) are not eligible to participate in the BMO-sponsored Medical Plan if you or your dependents elect coverage under Medicare Part D. In general, the prescription drug benefits provided under this plan are at least as good as or better than the standard Medicare Part D prescription drug benefits. However, you should review the coverages and premiums for both Medicare Part D and the Retiree Medical Program to make the best decision for you and your family.

If you decide to enroll in a Medicare drug plan you will no longer be eligible to participate in the Retiree Medical Program, and you permanently forfeit your rights to enroll in this plan in the future.

If you have any questions about Medicare Part D prescription drug coverage, refer to Important Notice from BMO Financial Corp. About Your Prescription Drug Coverage and Medicare or contact Medicare at 1-800-633-4227.

## *If you Enroll in Coverage*

When you complete and return the Retiree Medical Program Election/Waiver form indicating your medical plan election, your retiree coverage will be effective the first of the month following the month you retired.

**The form must be returned within 31 days of when active coverage ends, or when the packet is mailed, whichever is later.** This will expedite the set-up of your retiree medical coverage and avoid a delay of coverage or receiving new ID cards.

The member verification section on the Retiree Medical Program Election/Waiver form must be completed for all eligible dependents regardless if you will be enrolling them in a medical plan at the time of retirement. If you and/or your dependents are waiving retiree coverage, by declaring your eligible dependents you are maintaining their future eligibility to enroll later if they continue to meet eligibility requirements at that time.

Dependents that are not declared on this form at the time of your retirement will not be allowed to participate in the BMO Retiree Medical Program in the future, except for new biological or adopted children. (You will need to notify the Human Resources Centre at 1-888-927-7700 within 31 days of the birth or adoption).

## *Coordination of benefits*

The medical plans have a coordination of benefits provision that prevents duplication of benefit payments when you or your dependent also has other health coverage through another group plan, including Medicare. Coordination of benefits procedures also determine which plan pays your claim first. Refer to the Coordination of Benefits section in the summary plan description for more information.

## *If You Decline, Cancel, or Waive Coverage*

You have the option to waive your Retiree Medical Coverage through BMO and retain your Retiree Medical eligibility status (under certain circumstances) through the Retiree Medical Waiver Provision by completing the Retiree Medical Program Election/Waiver form**.**

**Your coverage will be cancelled effective the last day of the month in which your completed paperwork is received (or at the end of a future month if you indicate that on your form).**

### *Permanent Cancellation*

You will forfeit your eligibility for the Retiree Medical Program, or your coverage may result in permanent cancellation if you do not follow the provisions of the Retiree Medical Program. Any of the following events would result in permanent cancellation of your retiree medical coverage through BMO:

- You elect COBRA medical insurance at the time of your retirement.
- You do not return the Retiree Medical Program Election/Waiver form within 31 days of your retirement date indicating your intention to elect or waive coverage.
- You do not request re-enrollment in the Retiree Medical Program within 31 days of turning age 65, becoming Medicare Eligible or experiencing another qualifying event*. (Exception: You continue to be enrolled in other group coverage.)*
- You are Medicare Eligible because of age or disability and have not been enrolled in other group coverage continuously during your waiver period from the time you became Medicare Eligible.
- You enroll in Medicare Part D coverage. (*Does not apply to Legacy M&I Retirees)*
- You voluntarily choose to permanently cancel your coverage.

## *Retiree Medical Waiver Provision*

You and/or your eligible dependents have the option to waive your retiree medical coverage through BMO under the Retiree Medical Waiver Provision. This option allows you to retain your retiree medical eligibility

status and re-enroll when certain qualifying conditions are met. To enroll in the waiver program, indicate your intent to waive on the Retiree Medical Program Election/Waiver form**.**

This option may be beneficial to you if you are eligible for other employer group medical coverage through a spouse/domestic partner or other employer. If you choose to waive coverage, please carefully read through the provisions to understand your options. If you elect COBRA health insurance coverage at the time of your retirement, you will forfeit your right to participate in the Retiree Medical Program and therefore this waiver provision does not apply.

### *Eligibility for Waiver Provision*

Please refer to the Retiree Waiver Options Chart for rules that apply based on your age and/or Medicare status and how your election impacts your dependents.

If you are under the age of 65 and not Medicare Eligible and decide to waive enrollment, your eligible dependent(s) Consumer Choice Plan is automatically waived. You can only re-enroll when certain conditions are met or at the time you are newly eligible for Medicare because of age or disability.

If you are under age 65 and decide to waive enrollment, your spouse/domestic partner who is eligible for the Medicare Secondary Plan may continue enrollment in the Medicare Secondary Plan. However, if the retiree chooses not to enroll in the post-age 65 coverage when they become eligible, their coverage, if any, would be cancelled at that time.

| **Retiree Waiver Options Chart** | | | |
|---|---|---|---|
| **Retiree Age Status** | **Retiree Action** | **Spouse /Domestic Partner Age Status** | **Allowable Spouse/Domestic Partner Action** |
| **Retiree is under 65 or not Medicare Eligible** | Enrolls in Consumer Choice Plan - BCBS | Spouse/Domestic Partner is under 65 or not Medicare Eligible | Enroll on the Retiree's Medical coverage |
| | | | Waive coverage** |
| | | Spouse/Domestic Partner is over 65 or Medicare Eligible | Enroll in the Medicare Secondary Plan |
| | | | Waive coverage** |
| | Waives Retiree Medical pre-65 coverage* | Spouse/Domestic Partner is under 65 or not Medicare Eligible | Coverage is automatically waived* |
| | | Spouse/Domestic Partner is over 65 or Medicare eligible | Enroll in the Medicare Secondary Plan |
| | | | Waive coverage** |
| **Retiree is over 65 or Medicare Eligible** | Enrolls in Medicare Secondary Plan | Spouse/Domestic Partner is under 65 or not Medicare Eligible | Enroll in Consumer Choice Plan - BCBS |
| | | | Waive coverage* |
| | | Spouse/Domestic Partner is over 65 or Medicare Eligible | Enroll in the Medicare Secondary Plan |
| | | | Waive coverage** |
| | Waives Retiree Medical coverage due to enrollment in other group coverage** | Spouse/Domestic Partner is under 65 or not Medicare Eligible | Coverage is automatically waived* |
| | | Spouse/Domestic Partner is over 65 or Medicare Eligible | Enroll in the Medicare Secondary Plan |
| | | | Waive coverage** |

| | | | |
|---|---|---|---|
| | Waives Retiree Medical coverage. Does not enroll in other group coverage (Permanent Cancellation) | Spouse/Domestic Partner is under 65 or not Medicare Eligible | Permanently Cancelled |
| | | Spouse/Domestic Partner is over 65 or Medicare Eligible | |

### *Requesting Re-Enrollment*

To request re-enrollment in the BMO Retiree Medical Program you will need to submit a Retiree Medical Program Election/Waiver form to elect coverage.

**It will be necessary to provide supporting documentation of the qualified life event within 31 days from the qualifying event to enroll in the Retiree Medical Program.**

The following reasons are **NOT considered qualifying events** that would allow re-enrollment in the Retiree Medical Program:

- Annual enrollment;
- You discontinue coverage under an individual medical policy;
- You voluntarily discontinue other group medical coverage;
- You enroll in COBRA medical insurance through BMO;
- You discontinue COBRA medical insurance through another employer before the full COBRA period is exhausted for a reason other than an increase in cost or coverage curtailment as described above;
- You did not request re-enrollment within 31 days of when Medicare became your primary payer of your health coverage or within 31 days of a qualifying event.

| | |
|---|---|
| *** Pre-65 Waiver** | You have the option to waive your pre-65 coverage at any time with the opportunity to re-enroll once you meet one of the following guidelines. **You have 31 days from the date of the qualifying event to enroll in the Retiree Medical Program.**<br>• You become Medicare Eligible because of age or disability, you have 31 days from the date of becoming eligible for Medicare to enroll in the Medicare Secondary Plan, unless Medicare enrollment can be postponed due to enrollment in other group medical coverage. *Refer to the post-65 waiver provision for additional information on eligibility when you become Medicare Eligible.*<br>• You lose other group or state-provided medical coverage as a result of one of the qualifying events:<br>- a change in legal marital status or qualified domestic partner relationship;<br>- a change in employment status of the individual that carried the other employer group coverage;<br>- a change in benefit's eligibility status of the individual that carried the other group coverage;<br>- a change in residence.<br>• You experience a significant cost increase or significant coverage curtailment under your other employer group or state provided medical coverage. The cost must exceed the cost of what you would be paying for your BMO retiree medical coverage.<br>• An eligible spouse/domestic partner would be allowed to enroll in the retiree |

| | |
|---|---|
| | medical coverage in the event of the retiree's death if otherwise eligible under the Plan. The spouse/domestic partner must have a qualifying event consistent with re-enrolling in coverage as outlined above at the time enrollment is requested. |
| ****Post-65 Waiver** | You may waive or continue to waive your coverage after age 65 with the chance to re-enroll only if you have been continuously enrolled in other group medical coverage from the date the age 65/Medicare eligible waiver was effective until the time you are requesting re-enrollment in the Retiree Medical Program.<br>• It will be necessary to provide supporting documentation of continuous enrollment in other group medical coverage within 31 days of when you lose your other group coverage and Medicare becomes your primary payer. |

## *Death*

In the event of the death of a retiree, the retiree's dependents may continue coverage if the Plan is offered, and they meet the definition of an eligible dependent. If the spouse/domestic partner of the deceased retiree remarries or enters into another domestic partner relationship, the new spouse/domestic partner and any dependents of the new spouse/domestic partner are not eligible for coverage. Call the Human Resources Centre at 1-888-927-7700 to report any changes in status.

## *Rehired employees*

If you are rehired on or after January 1, 2008, you will become part of eligibility group 4 for the Retiree Medical Program. Your prior service time will be counted for Retiree Medical Program eligibility, however the timeframe you were not employed with BMO is considered a "break-in-service" and will not be counted in your service time calculation. Please note, your prior service time will not count towards eligibility for Company funding.

Individuals participating in the Retiree Medical Program immediately prior to the date of rehire are considered an active participant of the Waiver Program and will maintain their current Company contribution, if any, and current Retiree Group classification based on his/her initial retirement date. No additional service time is gained.

# *Plan cost*

You and the Company share in the cost of the Retiree Medical Program. Your share of the premium (and the premium for any eligible dependents you enroll) depends on:

- your years of benefit service under the Bank of Montreal/Harris Retirement Plan;
- your age;
- the medical plan coverage option you select.

Costs for the Retiree Medical Program are based on coverage and administrative fees for the retiree group and are different from the active employee rates.

## *How BMO Contributes*

BMO Financial Group made changes to the retiree medical benefits effective January 1, 2008, and your age and years of service (in months and years) as of December 31, 2007 will be used to determine the group you are classified under. The group will determine your access and Company contribution for retiree medical benefits.

### *How to Determine Your Years of Benefit Service*

In general, your service begins on your hire date with BMO, however, some employees will need to know their vesting service, while others will need to know their benefit service. Generally, benefit service begins on the actual date your company was acquired or the date your company joined the BMO/Harris Retirement Plan, whichever is later. See Companies Acquired by BMO Financial Group U.S. for more information.

You have the flexibility to view your service dates at any time by accessing your job details in Workday.

### *How to Determine Your Retiree Group*

In addition to meeting the eligibility and qualifications criteria to be eligible for retiree benefits, the following special rules apply:

| | |
|---|---|
| **Group 1 and Group 2** | Employees who on 12/31/2007 were age 55 or older with at least 10 years of benefit service* or age 45 or older with at least 60 points (your points are your age plus years of benefit service) will pay a percentage of the medical premium.<br>BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned (up to 35 years), BMO contributes an additional 2% of the premium, to a maximum of 75%. Your spouse/domestic partner and child(ren) will pay an additional 25% of the premium. See the Contribution schedule for more details.<br>* *Generally, your hire date with the Company can be used to determine your benefit service.* |
| ***Example***: A retiree with 25 years of benefit service will pay 45% of the monthly premium. The full monthly premium for the Consumer Choice Plan is $1,392.00, the retiree will pay 45% or $626.40 per month. The spouse pays an additional 25% of the full monthly premium, which means the cost for spouse coverage is 70% (45% + 25%) or $974.40. The total cost for retiree + spouse is $1,600.80 per month. | |
| **Group 3** | Employees who on 12/31/2007 were age 35 or older, who are not in Groups 1 or 2, for coverage before age 65, will pay a percentage of the medical premium.<br>Beginning at the age of 65 you will receive a subsidy from BMO to offset the cost of the |

| | |
|---|---|
| | BMO retiree medical plan.<br><br>This means that instead of paying a percentage of the premium, you will receive a capped annual subsidy of $70, times years of benefit service, up to a maximum of $2,450 per year (An aggregate of $600 less for your spouse/domestic partner/child(ren)). The value of your subsidy will be fixed when you reach age 65 – with no future increase. The subsidy will continue for your lifetime. In the event of your death, your spouse/domestic partner/child(ren) subsidy would also continue for his or her lifetime. |
| ***Example***: If you retire from BMO with 25 years of benefit service, BMO will pay $70 x 25, or $1,750 per year toward the cost of your retiree medical coverage once you are Medicare eligible because of age or disability. Your spouse's subsidy would be $1,150 per year. | |
| **Group 4** | Employees who on 12/31/2007 were under age 35 and who retire before age 65 will have to pay the full cost of coverage. BMO does not offer retiree medical coverage or the subsidy once you reach age 65. You would be responsible for your own coverage, which can be through Medicare and/or an individual insurance plan. |

| ***Contribution Schedule*** | | | | | |
|---|---|---|---|---|---|
| **Years of service** | **You Pay** | **Spouse Pays** | **Years of service** | **You Pay** | **Spouse Pays** |
| **10** | 75% | 100% | **23** | 49% | 74% |
| **11** | 73% | 98% | **24** | 47% | 72% |
| **12** | 71% | 96% | **25** | 45% | 70% |
| **13** | 69% | 94% | **26** | 43% | 68% |
| **14** | 67% | 92% | **27** | 41% | 66% |
| **15** | 65% | 90% | **28** | 39% | 64% |
| **16** | 63% | 88% | **29** | 37% | 62% |
| **17** | 61% | 86% | **30** | 35% | 60% |
| **18** | 59% | 84% | **31** | 33% | 58% |
| **19** | 57% | 82% | **32** | 31% | 56% |
| **20** | 55% | 80% | **33** | 29% | 54% |
| **21** | 53% | 78% | **34** | 27% | 52% |
| **22** | 51% | 76% | **35 or more** | 25% | 50% |

BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned (up to 35 years), BMO contributes an additional 2% of the premium, to a maximum of 75%.

Your spouse/domestic partner and child(ren) pay an additional 25% of the premium.

| Retiree Group | Your Plan Options | | How BMO Contributes | |
|---|---|---|---|---|
| **Employees who by 12/31/2007 were:** | **Under Age 65** | **Over Age 65** | **Under Age 65** | **Over Age 65** |
| 1<br><br>Age 55 or older with at least 10 years of benefit service* | You have access to the same plan options as active employees. (Consumer Choice Plan) | You will have access to the Medicare Secondary Plan. Medicare is primary and UMR is secondary.<br><br>Your prescription coverage is available through Express Scripts. | BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned up to 35 years, BMO contributes an additional 2% of the premium, to a maximum of 75%.<br><br>The spouse/domestic partner/child(ren) pays an additional 25% of the premium. | |
| 2<br><br>Age 45 or older with at least 60 points (your points are your age plus years of benefit service)* | You have access to the same plan options as active employees. (Consumer Choice Plan) | You will have access to the Medicare Secondary Plan. Medicare is primary and UMR is secondary.<br><br>Your prescription coverage is available through Express Scripts. | BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned up to 35 years, BMO contributes an additional 2% of the premium, to a maximum of 75%.<br><br>The spouse/domestic partner/child(ren) pays an additional 25% of the premium. | |
| 3<br><br>Age 35 or older (but not in either group above)** | You have access to the same plan options as active employees. (Consumer Choice Plan) | You will have access to the Medicare Secondary Plan. Medicare is primary and UMR is secondary.<br><br>Your prescription coverage is available through Express Scripts. | BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned up to 35 years, BMO contributes an additional 2% of the premium, to a maximum of 75%.<br><br>The spouse/domestic partner/child(ren) pays an additional 25% of the premium. | BMO will provide an annual subsidy that can be applied to the BMO plan. The annual subsidy will begin at age 65 and equal $70 times years of benefit service (up to 35 years) earned in the BMO/Harris Retirement Plan.<br><br>The spouse domestic partner/child(ren) would receive an aggregate of $600 less. |
| 4<br><br>Under age 35** | You have access to the same plan options as active employees. (Consumer Choice Plan) | No coverage available through BMO. | You pay the full cost of coverage. | N/A |

* Generally, your hire date with the Company can be used to determine your benefit service.

** Employees hired or rehired on or after January 1, 2008 will be part of Group 4.

## *How to Determine Your Share of the Monthly Premium*

To calculate your share of the premium you will need the full monthly retiree medical premiums and your contribution percentages.

| Pre-65/Not Medicare eligible Plan Option | Retiree Only or Spouse Only | Retiree + Spouse | Retiree + Child(ren) or Spouse + Child(ren) | Child(ren) Only | Family |
|---|---|---|---|---|---|
| Consumer Choice Plan 2023 rates | $1,392 | $2,784 | $2,088 | $696 | $3,480 |

| **Pre-65 Plan Option** **(Not Medicare Eligible)** | **How to calculate your share of the premium** | | |
|---|---|---|---|
| **Retiree Only** | Total premium = *Retiree Only* premium x Retiree Pays %<br>***Example with 20 years of service:*** $1,392 x 55% = $765.60 | | |
| **Spouse Only** | Total premium = *Spouse Only* premium x Dependent Pays % | | |
| **Retiree+Spouse**<br><br>Determine the share of the premium for the retiree versus the spouse and apply applicable percentages | Step 1<br><br>Retiree share of premium = *Retiree Only* premium x Retiree Pays % | Step 2<br><br>Spouse share of premium = (*Retiree+Spouse* premium - *Retiree Only* premium) x Dependent Pays % | Step 3<br><br>Total premium = Retiree share of premium + Spouse share of premium |
| ***EXAMPLE***<br><br>**Retiree+Spouse**: 14 years of benefit service | Retiree share of premium =<br><br>$1,392 x 67% = $932.64 | Spouse share of premium =<br><br>($2,784 - $1,392) x 92% = $1,280.64 | Total premium =<br><br>$932.64 + $1,280.64 = $2,213.28 |
| **Retiree+Child(ren)**<br><br>Determine the share of the premium for the retiree versus the child(ren) and apply applicable percentages | Step 1<br><br>Retiree share of premium = *Retiree Only* premium x Retiree Pays % | Step 2<br><br>Children share of premium = (*Retiree+Child(ren)* premium - *Retiree Only* premium) x Dependent Pays % | Step 3<br><br>Total premium = Retiree share of premium + Child(ren) share of premium |
| **Spouse+Child(ren)** | Total premium = *Spouse+Child(ren)* premium x Dependent Pays % | | |
| **Child(ren) Only** | Total premium = *Child(ren) Only* premium x Dependent Pays % | | |
| **Family**<br><br>Determine the share of the premium for the retiree versus the spouse & child(ren) and apply applicable percentages | Step 1<br><br>Retiree share of premium = *Retiree Only* premium x Retiree Pays % | Step 2<br><br>Spouse & Child(ren) share of premium = (*Family* premium - *Retiree Only* premium) x Dependent Pays % | Step 3<br><br>Total premium = Retiree share of premium + Spouse & Child(ren) share of premium |
| ***EXAMPLE***<br><br>**Family**: 23 years of benefit service | Retiree share of premium =<br><br>$1,392 x 49% = $682.08 | Family share of premium =<br>($3,480 - $1,392) x 74% = $1,545.12 | Total premium =<br><br>$682.08 + $1,545.12= $2,227.20 |

Premiums for individuals under age 65 are higher than for those that are over age 65 and/or Medicare Eligible. The reason is that Medicare pays a significant share of medical expenses for persons over age 65 and/or Medicare Eligible.

| **Post-65/Medicare Eligible Plan Option** | **Available to** | **Individual** |
|---|---|---|
| Medicare Secondary Plan<br>2023 rates | Medicare Eligible Individuals | $466.00 |

| **Post-65/Medicare Eligible Plan Option** | **How to calculate your share of the premium** | | | |
|---|---|---|---|---|
| Individual Only | Step 1<br><br>Retiree share of premium = *Individual Only* premium x Retiree Pays % | Step 2 *(if applicable)*<br><br>Spouse share of premium = *Individual Only* premium x Dependent Pays % | Step 3 *(if applicable)*<br><br>Child share of premium = *Individual Only* premium x Dependent Pays % | Step 4<br><br>Total premium = Retiree share of premium + Spouse+ Child(ren) share of premium |
| **Retiree+Spouse** ***example: 30 years of service*** | Retiree share of premium =<br><br>$466 x 35% = $163.10 | Spouse share of premium =<br><br>$466 x 60% = $279.60 | | Total premium =<br><br>$442.70 |

## *Paying for Retiree Premiums*

Retiree medical premium billing is administered by PayFlex Systems USA, Inc. If you would like to pay for your retiree medical premiums via automatic deduction from a checking or savings account, you must complete the PayFlex Automatic Premium Payment Electronic Funds Transfer (EFT) form and return as directed on the form. If you do not enroll in the automatic payment option and wish to pay your premiums by sending a check, you will receive coupons from PayFlex. Payments are due the first of each month and must be made within the 30-day grace period or coverage will be cancelled and cannot be reinstated.

You can view your account online by visiting www.payflex.com and completing the registration. Once you register you can manage your account online, view your payment history, and set up account alerts.

The portion that the Company pays toward the cost of retiree medical coverage, if any, for qualified domestic partners and domestic partner children is considered taxable. Retirees covering a domestic partner under the Retiree Medical Program will receive a Form W-2 each year reflecting this amount. In addition, you will be responsible for applicable payroll taxes.

# *Legacy M&I Retiree Medical Eligibility*

## Special Eligibility Provisions for former Employees of M&I Only

Your Retiree Medical Program eligibility is based off the provisions of the legacy M&I Retiree Medical Program if you were on staff as of July 5, 2011 and have not had a break in service after July 5, 2011. If you experienced a break in service after July 5, 2011 and were rehired, you need to satisfy the eligibility requirements of the BMO Retiree Medical Program provisions from your rehire date, unless you were eligible when you first terminated.

The Retiree Medical Program is available to eligible retirees and their eligible dependents based on the guidelines indicated below.

### *Eligibility and Qualifications for Pre-65 Coverage*

Different eligibility requirements and funding levels may apply if you were hired through one of the acquisitions or mergers as stated under the *Acquisitions/Mergers* section below.

Access to Pre-65 retiree medical coverage is available to employees ages 55 to 64 who at retirement meet the following requirements:

- are at least 55 years old;
- have at least 10 years of vesting service* with M&I and/or BMO; and
- have participated in any M&I and/or BMO medical coverage for at least 10 consecutive years immediately prior to retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement).

Retirees who meet the qualifications for the Retiree Medical Program who are eligible for Medicare will have coverage under the Medicare Secondary Plan. In the event you are eligible for Medicare; however, Medicare has determined that they will be the secondary payer to a group health plan; coverage will remain under the pre-age 65 plan until Medicare becomes the primary payer.

* *In order to earn one year of vesting service, you must be actively employed and work at least 1,000 hours during the year. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.

Special Eligibility for Retirees who were Employed by Metavante Corporation at the time Metavante Split from M&I Corporation on November 2, 2007: Retirees who met the above eligibility guidelines as of November 2, 2007 are eligible for the Retiree Medical Program as of the date they retire from Metavante Corporation. Funding level is based off of eligibility for the program as of November 2, 2007.

**Funding**

| **Employer Group**<br>**(Employees must also meet the requirements as stated under "Qualifications for Pre-65 Coverage" above)** | **Employer Subsidy towards the retiree group rate** |
|---|---|
| Active employees on staff prior to 9/1/97<br>(without a break in employment of more than 30 days on or after 9/1/97) | **60%** |
| Employees hired or acquired on or after 9/1/97 | **0%**<br>(Retiree pays 100% of the cost) |

## *Eligibility and Qualifications for Post-65 Coverage*

Different eligibility requirements and funding levels may apply if you were hired by M&I through one of the acquisitions or mergers as stated under the *Acquisitions/Mergers* section below.

Access to post-65 retiree medical coverage is available under the portion of the health program known as the Medicare Secondary Plan to employees ages 65 and older, and for who Medicare is the primary payer of claims, who at retirement meet the following requirements:

- are at least 55 years old;
- have at least 10 years of vesting service* with M&I and/or BMO; and
- have participated in any M&I and/or BMO medical coverage** for at least 10 consecutive years immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement).

Retirees who meet the qualifications for the Retiree Medical Program who are eligible for Medicare will have coverage under the Medicare Secondary Plan. In the event you are eligible for Medicare; however, Medicare has determined that they will be the secondary payer to a group health plan; coverage will remain under the pre-age 65 plan until Medicare becomes the primary payer.

When you enroll in the Medicare Secondary Plan, you are required to enroll in Medicare Parts A and B.

** In order to earn one year of vesting service, you must be actively employed and work at least 1,000 hours during the year. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

*** Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

***Special Eligibility for Retirees who were Employed by Metavante Corporation at the time Metavante Split from M&I Corporation on November 2, 2007****: Retirees who met the above eligibility guidelines as of November 2, 2007 are eligible for the Retiree Medical Program as of the date they retire from Metavante Corporation (or its successor). Funding level is based off of eligibility for the program as of November 2, 2007.*

**Funding**

The following chart applies to active employees on staff prior to September 1, 1997 (without a break in employment of more than 30 days on or after September 1, 1997):

| **Employee Group**<br>**(Employees must meet the requirements as stated under "Qualifications for Post-65 Coverage" in addition to the requirements listed below)** | **Employer subsidy towards the retiree group rate** |
|---|---|
| **Employees age 60 or older as of 8/31/02**<br>Who, at the time of retirement:<br>▪ meet the "Rule of 75" (age + years of vested service = 75) | 60% |
| **Employees age 55 to 59 as of 8/31/02**<br>Who, at the time of retirement:<br>▪ meet the "Rule of 75" (age + years of vested service = 75) | 40% |
| **Employees under age 55 as of 8/31/02** | 0%<br>(Retiree pays 100% of the cost) |
| **Employees over age 54 as of 8/31/02**<br>Who at the time of retirement:<br>▪ do not meet the "Rule of 75" (age + years of vested service = 75) | 0%<br>(Retiree pays 100% of the cost) |

***Employees hired on or after September 1, 1997*** **who meet the eligibility requirements as stated under "Qualifications for Post-65 Coverage" are eligible for access to retiree medical coverage (the retiree pays 100% of the retiree group rate).**

### *Waiver Provision Prior to Retirement*

After December 31, 2006, if you are age 55 or older, have 10 or more years of vested service, and have participated in a Company-sponsored health plan for 10 or more consecutive years, you may waive your medical coverage as an active employee **without** losing your eligibility for retiree coverage. As long as you meet these requirements at the time of the waiver, you do not have to meet the 10-year participation requirement immediately prior to retirement. If you waived your M&I medical coverage prior to January 1, 2007 when this provision was implemented, this provision does not apply.

If you choose to waive your medical coverage as an active employee, you may do so during the annual enrollment period or as the result of a qualifying event by making your changes via the online benefits portal. You may re-enroll in coverage during the annual enrollment period (effective the following January 1st); as the result of a qualifying event (effective based on rules under Qualifying Life Event); or at retirement (effective the day following your last working day).

**Please note:** Enrollment rules vary by health plan and all current options may not be available at the time you request re-enrollment.

## *Acquisitions/Mergers*

The following guidelines apply to both pre- and post-age 65 coverage.
Employees who were hired by M&I through an acquisition or merger *prior to September 1, 1997** fall under the guidelines indicated in the above sections. The 10-year participation in an M&I and/or BMO health plan requirement will be waived, provided you meet the following guidelines:

- You enrolled in any M&I or/or BMO health plan at the time of the acquisition/merger and have been continuously enrolled immediately before your retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement).
- You have not had a break in service of more than 30 days since the acquisition/merger date. You meet the other requirements as stated in the above sections: you are at least age 55 at the time of your retirement, and you have at least 10 years of vested service (vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I & BMO and/or the previous employer; any time after 2004 during which you receive severance pay is treated the same as full-time active employment). *Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will*

*be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

**Additional qualifications for eligibility and employer funding may apply if you were hired by M&I through a merger or acquisition on or after September 1, 1997* as indicated below.**

** Former employees of Valley Bancorporation fall under the guidelines as indicated below.*

**Eligibility/Funding**
If you were hired by M&I through one of the acquisitions or mergers indicated below, you are eligible for access to retiree medical coverage if at retirement:

- you are at least 55 years old; and
- you meet the requirements as indicated by the categories below.

**The guidelines below apply to former employees of Valley Bancorporation – Acquired by M&I 6/1/94:**

- Eligible employees who retired *prior to January 1, 1995*, are eligible for employer funding based on years of vested service*:

| Years of Service | Employer Funding |
|---|---|
| 0 – 9 | 0% |
| 10– 14 | 20% |
| 15 – 19 | 30% |
| 20 – 24 | 40% |
| 25+ | 50% |

- Employees who retire *on or after January 1, 1995*, are eligible for the following:
  - Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by the acquired company and/or M&I** and/or BMO immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
  - 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by Valley Bancorporation and/or M&I** and/or BMO immediately before retirement: retiree medical coverage is available at 100% of the retiree group rate.
  - 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan** following the acquisition and immediately before retirement: retiree medical coverage is available based on the guidelines as described under the *Qualifications for Pre-65 Coverage* and *Qualifications for Post-65 Coverage* sections above.

** Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I and/or BMO and/or Valley Bancorporation. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

*** Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

**The guidelines below apply to former employees of the following acquired companies:**
**Central Fidelity Bank – Acquired by M&I 9/1/97**
**Security Bank – Acquired by M&I 10/1/97**
**Citizens Bank – Acquired by M&I 11/1/97**
**Advantage Bank – Acquired by M&I 4/1/98**
**Fifth Third Bank – Acquired by M&I 9/8/01**

- Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by M&I** and/or BMO immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by the acquired company and/or M&I and/or BMO ** immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): retiree medical coverage is available at 100% of the retiree group rate.

** Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I & BMO and/or the previous employer. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

*** Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

The guidelines below apply to former employees of National City Bank (NCB) – Acquired by M&I 8/1/01:

- Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by M&I** and/or BMO immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by the acquired company and/or M&I and/or BMO ** immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): retiree medical coverage is available at 100% of the retiree group rate.

***Grandfathered Employees:*** Employees at least age 55 with 10 or more years of vesting service* at the earlier of June 30, 2002 or the date of retirement, and 10 or more consecutive years of participation in a health plan sponsored by NCB or M&I or BMO as of the date of retirement are eligible for pre-age 65 funding based on the declining scale below:

| Year | Employer Funding |
|---|---|
| 2004 | 35% |
| 2005 | 30% |
| 2006 | 25% |
| 2007 | 20% |
| 2008 | 15% |
| 2009 | 10% |
| 2010+ | 0% |

** Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I and/or BMO and/or the previous employer. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

*** Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

**The guidelines below apply to former employees of the following acquired companies:**
**First Indiana Bank Trust Company – Acquired by M&I 1/1/06**
**First Indiana Bank – Acquired by M&I 1/1/08:**

- Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by acquired company and/or M&I and/or BMO *** before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by the acquired company and/or M&I and/or BMO *** before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): pre-age 65 and post-age 65 retiree medical coverage is available at 100% of the retiree group rate.

***First Indiana Bank Grandfathered Employees:*** Employees who meet the Rule of 75 (age + years of vested service is equal to or greater than 75*) as of December 31, 2007, are eligible for pre-age 65 employer subsidy based on the following declining schedule in place at the time of retirement provided they meet the eligibility guidelines as described above at the time of retirement:

| Year | Employer Subsidy** |
|---|---|
| 2008 | 75% |
| 2009 | 50% |
| 2010 | 25% |
| 2011+ | 0% |

***The subsidy is applied to the portion of the premium which is equal to the difference between the adjusted 2007 First Indiana plan rate and the current retiree group rate. Any remaining portion of the premium is not subsidized. (Employer funding is **not** provided to former employees of First Indiana Bank Trust Company.)*

*Post-age 65 retiree medical coverage is available at 100% of the retiree group rate to former employees of First Indiana Bank and First Indiana Bank Trust Company.*

**Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I and/or BMO and/or the previous employer. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Any time after 2004 during which you receive severance pay is treated the same as full-time active employment.*

***Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*
**The guidelines below apply to former employees of the following M&I acquired companies**:

| Acquired Company | Acquisition Date |
|---|---|
| CardPro | April 1, 1999 |
| Traveler's Express | April 9, 1999 |
| HUBCO | November 13, 1999 |
| Derivion Corporation | June 1, 2001 |
| CyberBills | June 21, 2001 |
| Brokat | September 8, 2001 |
| 401k Services.Com | December 20, 2001 |
| Century Bank | March 1, 2002 |
| Richfield Bank | March 1, 2002 |
| TrustStar Retirement Services – Glendale location | April 8, 2002 |
| – San Mateo location | April 15, 2002 |
| Beneplan | May 1, 2002 |
| Paytrust, Inc. | July 22, 2002 |
| Southwest Bank | October 1, 2002 |
| Printing for Systems, Inc. (PSI) | November 15, 2003 |
| AmerUs Home Lending Inc | January 1, 2004 |
| United Missouri Bank | Various acquisition dates by individual |
| Kirchman Corporation | May 28, 2004 |
| Advanced Financial Solutions (AFS) | July 1, 2004 |
| NYCE Corporation | July 30, 2004 |
| Response Data Corporation (RDC) | September 8, 2004 |
| NuEdge | October 20, 2004 |
| VECTORsgi Holdings Inc. | November 22, 2004 |
| Prime Associates, Inc. | February 9, 2005 |
| MBI Benefits, Inc. | July 22, 2005 |
| TREEV | August 8, 2005 |
| GHR | August 11, 2005 |
| Brasfield Technology, LLC | October 6, 2005 |
| Link2Gov | November 30, 2005 |
| AdminiSource Communications | January 3, 2006 |
| Gold Banc Corporation, Inc. | April 1, 2006 |
| Trustcorp Financial, Inc. (Missouri State Bank and Trust Company) | April 1, 2006 |
| VICOR, Inc. | September 2, 2006 |
| Valutec Card Solutions, LLC | January 17, 2007 |
| United Heritage Bank | April 1, 2007 |
| North Star Financial Corporation | April 21, 2007 |
| Excel Bank Corporation | July 1, 2007 |
| Citizens Bank (asset purchase) | January 1, 2008 |
| Taplin, Canida & Habacht, Inc. (TCH, LLC) | January 1, 2009 |
| U.S. Bank (asset purchase) | May 3, 2010 |

- Less than 10 years of vesting service with M&I and/or BMO * following the acquisition, and less than 10 consecutive years of participation in any health plan sponsored by M&I and/or BMO ** immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service with M&I and /or BMO * following the acquisition, and 10 or more consecutive years of participation in any health plan sponsored by M&I** and/or BMO immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): retiree medical coverage is available at 100% of the retiree group rate.

** To earn one year of vesting service, you must be actively employed and work at least 1,000 hours with M&I and/or BMO during the year. Exempt-level employees, and employees on Military Leave, may be credited with*

*95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

***Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

## *Eligibility for Medicare Part D and BMO Retiree Coverage*

***Former Employers of Marshall & Ilsley Corporation***

If you are enrolled in the BMO Group Medical Plan and you elect one of the Medicare prescription drug plans, the prescription drug coverage under the Group Medical Plan will be cancelled. Medical coverage will not be cancelled; however, you will continue to pay the full premium amount. If you later decide to cancel your Medicare prescription drug plan, the prescription drug benefit under the BMO medical plan will be reinstated, but only if you have continued to be enrolled in the BMO Retiree Health Program.

If you have any questions about Medicare Part D prescription drug coverage, refer to Important Notice from BMO Financial Corp. About Your Prescription Drug Coverage and Medicare or contact Medicare at 1-800-633-4227.

## *Plan Cost*

You and the Company share in the cost of the Retiree Medical Program. Your share of the premium (and the premium for any eligible dependents you enroll) depends on:

- your years of benefit service under the M&I and/or BMO medical coverage;
- your age; and
- the medical plan coverage option you select.

Note: Costs for the Retiree Medical Program are based on coverage and administration fees for the retiree group and are different from the active employee rates.

### *How to Determine Your Share of the Monthly Premium*

To calculate your share of the premium you will need the retiree medical rate to determine your amount. To calculate your share of the premium:

- **Step 1:** Determine the full premium amount for the option you are choosing.
- **Step 2:** Apply your applicable (pre-65 coverage or post-65 coverage) contribution percentage.

Example: You and your spouse are both under 65: Total premium = *Retiree+Spouse* premium x your contribution % for pre-65 coverage. Eligible dependents will receive the same contribution percentages that the retiree is eligible for. Refer to How to Determine Your Share of the Monthly Premium for the full retiree rates.

Premiums for individuals under age 65 are higher than for those that are over age 65 and/or Medicare eligible. The reason is that Medicare pays a significant share of medical expenses for persons over age 65 and/or Medicare eligible. Your premium amount will be reduced automatically on the first day of the month in which you qualify for Medicare or the first day of the previous month in cases where the date of birth is on the first of a month. On that date, Medicare becomes your primary insurance coverage, and the Company's plan becomes secondary.


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Effective Date: January 1, 2023

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

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